

PHILADELPHIA MEDICAL TIMES.

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No. 523.

DECEMBER 15, 1887.

VOL. XVIII

CLINICAL LECTURE.

ON A CASE OF IDIOPATHIC PERICARDITIS.

BY PROF. J. M. DA COSTA, M.D., LL.D.,
Delivered at the Pennsylvania Hospital, December 10, 1887.

GENTLEMEN:—This boy, an Italian, was admitted into the hospital on the fifth of this month. He came in very ill and evidently in great danger. His history was difficult to obtain, owing partly to his physical state and partly to his inability to communicate with us intelligently. Yet we were able to gather from him these facts: He has been in this country for two years; during this time he has been chiefly engaged in tailoring work. While in Italy he had, occasionally, attacks of sharp pain in the cardiac region, but no other symptom of heart disorder; the cardiac distress was not very marked. He never had an attack of acute rheumatism, nor, indeed, rheumatism in any form. He does not recollect having had any acute illness previous to the occurrence of the cardiac pain. He was not subject to palpitation of the heart, and there was no dyspnoea.

Now, these are the statements I find in the notes; how correct they are I cannot say. He gave his history just

as I have told you, and some of his statements may be inaccurate: that one about the dyspnoea I should fairly question.

His present illness, the one for which he was admitted into the hospital, began about a month ago with a chill and severe pain in the cardiac region. Please note that. This was followed by dyspnoea and palpitation of the heart; he never had any pains in any other part of his body than the cardiac region. These symptoms continued until his admission; the pain he described as being a sharp, acute pain. On admission, the boy, as I have already told you, was very ill, but he had not a high temperature; his tongue was clean and pale; his bowels constipated. His only complaint was of pain and oppression in the heart and some difficulty in breathing. His face was extremely pale and somewhat swollen, so much so that his appearance suggested a kidney affection. The urine was examined, but it lent no countenance to this view. The specific gravity was 1020; it was of acid reaction, and free from albumen and from sugar. He was, as I have told you, excessively pale, and presented the appearance of great debility and anemia, without dropsy; there was not even swelling of the feet.

Now, gentlemen, the physical condition which this patient presented at this time are practically unchanged to-day. I will therefore make a careful examination before you and tell you what the physical signs were upon admission by telling you what they are now. I must say that in one respect the state is modified: his general condition is very much improved, his pulse is of better volume and strength and his dyspnea is not so marked.

So as to bring up his history to the point of the present examination, I will further state that he had no fever since his admission. When I say that he has had no fever, I mean that the temperature has been uniformly less than 100° and has been rarely quite 99° . The temperature therefore is very slightly, if at all, elevated.

I will now proceed to examine his condition. His tongue is clean and of good color. His respirations are 24 in the minute; his pupils are somewhat dilated. His lips are of good color and his ears slightly reddened as if from capillary stasis. His face has lost a good deal of the pallor and swelling which it presented upon admission. When now I examine his heart, I find a diffused impulse perceptible in the epigastrum and extending to the upper border of the sixth rib on the line of, or even slightly, outwards from, the nipple. The transverse dulness in the cardiac region is distinctly increased, passing almost to the right edge of the sternum. We have thus a diffused impulse seen at the epigastrum and as far out as the nipple line. By placing my hand over this region, I find that while the impulse is diffused, it is only moderately forcible. When now I put the stethoscope over the heart, I find this state of things: A systolic murmur, rough in character, is heard at the apex of the heart, is perceived in the line of the anterior border of the axilla, also posteriorly at the angle of the left scapula. When I pass the stethoscope on to the base of the heart, especially towards the left, I find a double sound, apparently a murmur, but it is a friction sound; the second part of which (that which follows the systole), is much the more distinct, but broken up into several rather coarse kind of sounds. In other

words, we have a double pericardial friction, with a "to-and-fro" murmur, of which the second or "fro" part is split and rough. Of these, the first alone, strictly speaking, simulates a murmur. We further find that this friction sound is heard a little to the right of the sternum, where the so-called crackling sounds of pericardial friction are also present; but as I go away from the cardiac region these sounds become very indistinct; in the carotids, in that of the left side especially, a rather faint systolic murmur is perceived.

The lungs are clear on percussion. I hear the vesicular murmur distinctly at the lower part of the lungs; quite low down on the right side there is a slight impairment of resonance; in other words, slight congestion. His lungs are now comparatively clear, barring this slight congestion; he has still some shortness of breath, but the pain is much better. For the last two nights he has not required any opium for the relief of pain, which before this had been absolutely necessary.

I have told you that the physical signs are practically the same now as when he was admitted. So they are in the main. But the murmur at the apex is a little more distinct than when he first came in. On the other hand, the pericardial friction is not quite so marked as on admission; it has become softer, and is not the distinct "to-and-fro" sound which we first noticed. One other point I will ask you to note with regard to this sound: as on admission, it is very much increased upon pressure. By pressing on the stethoscope I develop it in greater intensity, and make it rougher. As I listen I can now make out a short, distinct, second cardiac sound which before was obscure.

Now, what have we here? Pericarditis, I have already told you, but of what character? There is no effusion of serum, but some plastic lymph has been here thrown out, most at the base of the heart, where there are recent changes. Here arises an interesting question; granted that this is a case of pericarditis, we must have another explanation of the systolic murmur which is heard at the apex, and also at the inferior angle of the scapula.

There must also be endocarditis—a lesion of the mitral valves, with insufficiency and regurgitation. Now, can we go further? Is this acute or chronic? The diagnosis I will make is this: The pericarditis is acute; the valve disease is chronic.

He once had pains in the cardiac region while in Italy. It is possible that this was the beginning of the mitral affection. He had no rheumatism, so far as we can learn. Now my opinion is that the valvular lesion is chronic. The increase in the size of the heart, the diffused impulse, the increased area of percussion dulness, are against the view that all has been recent, as this increase in transverse dulness is not due to a large effusion, which, I have already told you, does not exist.

But, what about the pericarditis? This was acute. The fact that the sounds have been modified under treatment, the history of the acute beginning, the pain and the dyspnoea which came on suddenly—all this shows the pericarditis to be acute. A recent, acute, plastic pericarditis, with soft lymph thrown out around the base of the heart, co-existing with old mitral insufficiency and regurgitation. So much for the diagnosis. Now, what is the prognosis? I think he will recover. He is recovering rapidly now. Of course, the disease of the mitral valve will remain, while the pericarditis will very largely disappear, perhaps entirely. He may get quite as well as before this attack came on.

Now, this is one of those extremely rare cases of idiopathic pericarditis; pericarditis without apparent cause. The majority of cases of acute pericarditis arise in the course of acute rheumatism. This boy has not had a sign of acute nor even of sub-acute rheumatism. Pericarditis also arises in the course of Bright's disease; he has not a kidney lesion. Then we must not overlook the possibility of pericarditis arising in pyæmia; morbid material in the blood after traumatism or an operation is likely to give rise to pericarditis. There is no evidence of injury, and he has not had the sweating nor the alternations of temperature which accompany pyæmia. Nor has there been any local cause, such as a

blow on the chest. It is a case of purely idiopathic pericarditis; a condition so rare that its very existence has been denied by some. But it sometimes happens nevertheless. I can recall seeing other cases, both in private practice and in hospitals. I know that the affection happens, and here is an illustration of it.

The next question is the treatment. He has been taking opium at night and Rochelle salt in the morning, with half an ounce of acetate of potassium daily. To this has been recently added tincture of the chloride of iron, twenty drops, three times a day. Turpentine stupes have been applied over the cardiac region, but no poultices.

He has had a nourishing diet, without stimulants. Under this treatment he has strikingly improved. The urinary secretion is freer than before taking the acetate of potassium and tincture of iron, and I see no reason for changing this treatment. He has greatly gained in appearance and I am now also able to say that there is an improvement in the physical signs.

The time has come when the application of a small blister over the heart will aid in the absorption of the exudation. I have said that he has not had stimulants. I would have given him stimulants if there had been any failure of the heart, or it had become decidedly irregular in its action.

It might also have been proper to have given digitalis, but the necessity for it did not arise. His pulse has been between 100° and 108° in the minute, and regular in its rhythm. We shall not give him digitalis while his pulse continues this way; if it become weak or irregular we will give him a grain of digitalis twice daily or oftener.

The acetate of potassium acts as a diuretic, and aids in the absorption of the lymph. The object of giving the chloride of iron may not be so clear to you, but it was given to improve his general condition and his blood, and the result has been good.

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The *Medical Analectic* has joined the ranks of the weeklies. This will be welcome news to its readers. We wish it all success.

ORIGINAL COMMUNICATIONS.

CASCARA SAGRADA.

(RHAMNUS PURSHIANA, D.C.)

BY H. H. RUSBY, M.D.,
of New York.

In the *Ephemeris* for October (pp. 984 and 1050), Dr. Squibb, in a half-apologetic fashion, attempts to explain his obstinate and unique antagonism to Cascara Sagrada. It seems that, some fifteen years since, Dr. Squibb introduced the Buckthorn (*Rhamnus Frangula*, *L.*) to the medical profession of America. Five years later Messrs. Parke, Davis & Co., of Detroit, introduced the Cascara Sagrada. In the meantime, the Buckthorn has never met with much success, and is known to the great body of the profession as a name only, while the success of the Cascara has been phenomenal. As the position of the *United States Pharmacopœia* in rejecting a drug that is successfully used by physicians almost without exception, and retaining one that is prescribed only by a small clique, is growing very equivocal, Dr. Squibb comes forward to show that the *R. Frangula* is the superior article, but that the *R. Purshiana* has been raised into prominence by vigorous advertising. To this the medical editor might, with great propriety, reply that if it were true, then the vigorous advertising referred to is one of the greatest of boons, for it has brought comfort to a half a million suffering mortals who might otherwise have languished on without assistance. But it is not true. Vigorous advertising can bring an article into notoriety, but intrinsic merit alone can give to it a permanent repute.

What we are interested in is the fact that some of the positions taken in the articles referred to are so directly at variance with the facts as to shock the sense of scientific accuracy. The paper opens with the statement that "Rhamnus Purshiana is a sub-variety of the Buckthorn family." Now, to a botanist, this statement is merely laughable. It has absolutely no meaning when scientifically interpreted. It is precisely as though a genealogist were to attempt to define the relationship between John Smith and Peter

Jones by saying that "John Smith is an approximate cousin of Peter Jones's correlative Adamitean descendant." It is absolutely unintelligible. Sub-varieties do not belong to families, but to varieties, and these in turn to species, which form genera, the last going to make up families. But *Rhamnus Purshiana* is not a sub-variety at all. It is not even a variety, but a species, the rank of which, determined by a hundred botanists of distinction, has been recorded in a hundred standard works, and never questioned until it is so done in the unintelligible language of the writer here referred to. But, what is worse, we cannot believe that the language employed is the result of either ignorance or accident. It seems incredible that a gentleman so long connected with botanical drugs should be ignorant of the first principles of classification. It seems to be rather an attempt to lead people to entertain the false impression that the *R. Purshiana* is only a variety of the *R. Frangula*. That it has really produced this effect is apparent from the many inquiries that have reached the writer in his capacity as a medical botanist, as to whether the "Cascara Sagrada really is only a sub-variety of the Buckthorn!" In reply I desire to make public, in the most complete manner, the relations between the two.

In a foot-note I append, on the following page, for the benefit of those especially interested, a complete description of the two species. Here I present, contrasted in tabular form, the chief characteristic distinction.

From a consideration of the foot note it will be seen that so far from these two species being forms of the same, they really have almost nothing in common, being as distinct as two species in the same genus could be, there being no portion of the plant but shows its distinctive specific mark. And it is to be observed that we have here presented only the most obvious characters of the two species, the less conspicuous, but important characters of the seeds and other obscure portions not being referred to. The number of seeds in this genus is accepted as a most important classificatory mark. *R. Frangula* has 2, *R. Purshiana* 3, and

R. Catharticus has 4. If Dr. Squibb had desired but to break down the individuality of *R. Purshiana*, without bolstering up his own introduction, he would have associated it with our East American species, with which it has certain affinities, and of which it was formerly considered a form, and not with the wholly dissimilar European species. If anything could render the position more absurd, it is the fact that the *R. Frangula* is a plant of Europe, extending somewhat into Asia, but forming no part of that Asiatic flora which it is fair to suppose may have extended itself to some extent into our western borders.

Now, as regards the bark of *Cascara sagrada*, which is generally thrown down upon our market, we cannot deny, but that much of what Dr. Squibb's says in following, is true of it. Its identity is most uncertain. The fact has never been sufficiently impressed that the Pacific coast and Rocky Mountain region abound with other varieties of *Rhamnus* entirely distinct from the *R. Purshiana*, but which may easily be, and unquestionably frequently are, mistaken for it. That Dr. Squibb, himself, has committed the same error, we infer from the fact that he states that the plant is so abundant, that the bark can be purchased of good quality at 8 or 9 cents per pound; while we have little knowledge of the relative market prices of the barks, yet, this statement seems to us incredible. Our mind reverts to the appearance of the tree as we saw it, when making natural history collections in the Rocky Mountain region, under the auspices of the Smithsonian Institution, many years ago. It was by no means a common occurrence to find a

locality where it might truly be said to be abundant. The *R. Californica*, on the contrary, with its *var. tomentella*, was so. This species frequently covered acres with a shrubby growth, while single individuals of the true *R. Purshiana* were seen scattered through it. It seems perfectly reasonable to suppose that these two very similar species of barks are often collected promiscuously. This supposition is rendered almost certain when we consider the marked discrepancies between the action of some of the cheaper preparations, and of that coming from the house most interested in maintaining the reputation of this drug; in which, although made absolutely free to their competitors, they yet take a pardonable pride, (it being strictly of their own introduction), while they observe the most rigid precautions, involving great expense, to insure the genuineness of the stock which they employ. Certainly, a bark shipped great distances to the railway station and transported across the Continent, which can still be offered at 8 or 9 cents a pound, is fairly open to the suspicion of having been collected in the most careless fashion. From my knowledge of this plant in its native habitat, I regard the difficulties of securing an absolutely reliable stock of the bark as exceptionally great, and I should regard all cheap preparations of it with the gravest suspicion. With such an admitted cheap preparation made, and distributed by one who is interested in breaking down the reputation of one of the agents and, (as intimated), placed in the hands of those in sympathy with his prejudices, there is, unfortunately, little to be hoped from the series of comparative experiments which he claims to have instituted. To

R. Purshiana, D. C. (*Cascara sagrada*).

Plant.—Grows in river bottoms and plains as a small tree, the trunk often nearly a foot in diameter.

Leaves, 3 to 5 inches long. Margins denticulate serrate. Under surface strongly pubescent. Lateral veins 14 to 16, prominent.

Inflorescence.—In umbels of 10 to 20 flowers. Flower-stems longer than the leaf-stems, pubescent.

Anthers yellowish.

Fruit black, pear-shaped.

Seeds, three.

Habitat.—Rocky Mountains and the Pacific coast.

R. Frangula, L. (Buckthorn of Europe).

Plant.—Grows usually as a shrub in hedge-rows, etc., scarcely more erect than the well-known *R. catharticus*.

Leaves, 1½ to 3 inches long. Margins entire (or barely sinuate?). Under surface sometimes minutely downy. Lateral veins 10 to 12; merely nerve-like.

Inflorescence.—Only 2 or 3 together in the axils. Flower-stems short and smooth, or nearly so.

Anthers purple.

Fruit purple, rounded.

Seeds, two.

Habitat.—Europe and Asiatic Russia, except the north.

have appealed to the just senses of the thousands interested in such a trial, there should have been no question as to the genuineness of the products employed. But the trial, after all, is quite superfluous and can be instituted only in the interest of private enterprise. The medical profession of England, and America, have already decided this question with scarcely a dissenting voice. Both species of bark have now been on the market for a dozen years or so, and have had a fair trial. Fifty thousand physicians are daily using Cascara sagrada as the result of years of practical experience, while scarcely as many scores are using the Buckthorn. The annual consumption of Cascara sagrada bark is about double that of rhubarb, and it all goes through the prescriptions of physicians. To accuse this great body of practitioners of incompetence, and to assert that they are the victims of advertisements, which they have not the professional skill to test, is manifestly absurd, and can be by no means pleasant to those who are thus belittled. It is very evident that the ordinary practitioner of medicine is just as competent to recognize the fact that he has brought his patient to the point of defecating with regularity and ease, as is a Da Costa, or a Loomis.

That the U. S. Pharmacopœia has taken the ground that it has is the business of its revisers. If a few men, however eminent, are willing to antagonize the great body of American physicians, as they have done in the case of assayed drugs and other particulars, merely to humor the private prejudices of a certain number of their associates, it is their own misfortune. The revisers of the British Pharmacopœia, after a most thorough investigation, admitted R. Purshiana in preference to their own native species, and only added the latter as a concession to secure uniformity.

Even the domestic history of the two barks is sufficient to establish the facts in the mind of any unprejudiced person. Loudon, himself, in describing the R. Frangula, speaks of it as a "sharp purge," and its household reputation in this direction is perfectly well known. This reputation it has

not acquired through the employment of fresh samples, for the peasants are fully aware of the desirability of reserving the bark a long time before using. It is safe to say that where one dose is taken in a fresh condition, a hundred doses are prepared from bark which has been stored for years. So powerful, indeed, is the bark of the European Buckthorn, that it is recognized as one of the surest purges for cattle and horses, and it even produces serious results when eaten in pasturing. Now it must be evident to even the dullest intellect, unless that intellect be blinded by prejudice, that a drug which is used by mankind as a "sharp purge," and administered to cattle and horses as an irritant cathartic, is not an agent to be employed in long continued doses for overcoming chronic constipation; and the individual who, to indulge feelings of personal envy, will apply or imply the epithet of fool to every physician who subscribes to this very obvious proposition, will gain no credit thereby. The cascara, on the other hand, is noticeably mild in its action from the very beginning. It is this very property which has brought it into the universal esteem that it now enjoys. To single out such a drug for attack on the assumed ground of effects exactly opposite to those which have given to it its reputation, exhibits no less temerity than disregard for facts.

If we were not willing to accept the lesson taught by the domestic reputation of the two drugs, and if we had no confidence in the perceptions of the great mass of the medical profession, we should still have the testimony of the most eminent authorities in favor of R. Purshiana. No more competent corps of observers exist on either continent than the board of revisers of the British Pharmacopœia, and they have decided as to the pre-eminent merits of the American species. On the continent the great Senator has established its superiority by a series of comparative studies of so exhaustive a nature that they leave no doubt as to the merits of the case.

To multiply evidences on this subject is idle. There can be no better argument in favor of the superiority of

the Buckthorn than its foreign origin, which will doubtless lend to it a prestige in the eyes of a certain class of very un-American Americans.

Rhamnus Purshiana.—Leaves broadly elliptical, denticulate—serrate, pubescent beneath. Umbels axillary, peduncles longer than the petioles, pubescent. Petals embracing the very short stamens; stigmas 3. Fruit turbinate, 3 seeded. Shrub or small tree 10 to 20 feet high, with a trunk 9 inches in diameter. Leaves 3-5 inches long, and $1\frac{1}{2}$ to 2 inches broad, sometimes slightly cordate at the base, rarely acute, or slightly acuminate; lower surface strongly pubescent; veins 14-16, prominent. Umbels 10-20 flowered. Petals 2-lobed. Styles rather short. Fruit of the size of a large pea; black. Seeds plano-convex, without a groove; shining. Fruit pear-shaped. (From Torrey and Gray's Flora, of N. A.)

Rhamnus Frangula.—More erect than the common Buckthorn (*R. Cartharticus*), not thorny. Leaves broader and more obtuse, entire or slightly sinuate, having sometimes a minute down on the under side. The lateral veins more numerous, diverging equally from the mid-rib almost the whole of its length. Flowers 2 or 3 together in each axil, all hermaphrodite; the minute petals, calyx-teeth, and stamens in fives. Fruit dark purple, of the size of a pea. In hedges and bushy places, throughout Europe and Russian Asia, except in the extreme north. In Britain rather more frequent than the common *R.*, but still rare in Scotland. Flowering in spring and early summer. (From Bentham's Hand Book of the British Flora.)

Loudon says of the same species: "Leaves quite entire, with 10 or 12 lateral nerves. Flowers whitish with purple anthers. Berries 2-seeded. The berries dye yellow, and the bark dyes a tawny color. A sharp purge, and a very certain purge for cattle."

The annual meeting of the Pennsylvania Forestry Association was held at the Hall of the College of Physicians, December 9th, at 8 o'clock P. M.; at which addresses were made by Dr. Rothrock, President of the Association, Mr. Bernard E. Furnow, Chief of the U. S. Forestry Division, Dr. Anders and others.

A NEW PATTERN OF AN OPH-THALMOSCOPE.

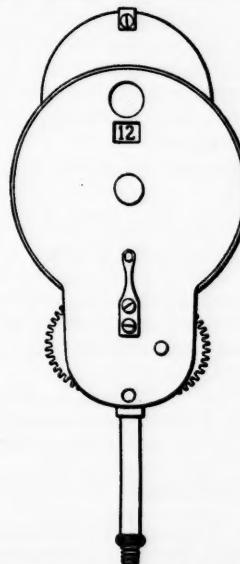
BY PETER D. KEYSER, A.M., M.D.,

Professor of Ophthalmology in the Faculty of the Medico-Chirurgical College, Philadelphia.

(Presented to the Section in Ophthalmology, International Medical Congress, Washington, D. C., September, 1887.)

THE nearest to perfection of an ophthalmoscope, that has been given to the profession, is the large one of Knapp, with the two discs of convex and concave glasses revolving over each other. This instrument, however, is too large and too expensive for general use. Furthermore, it is not arranged so that the rotation of the discs can be made with the fingers of the hand while holding it before the eye. It is so large that it will not go under the brow and close to the eye, but rests upon the brow, which keeps it a distance from most eyes.

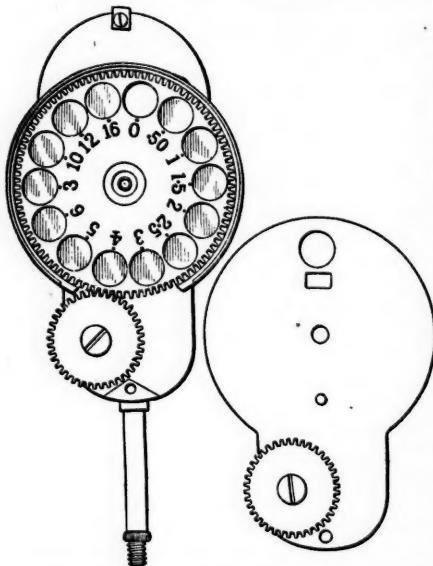
The great desideratum in an ophthalmoscope is to be able to make all the changes in the glasses during the observation without taking it from the eye, on account of the activity and ready involuntary changes of the accommodation. Most all of the late patterns of this instrument require to



be removed to adjust some weaker or stronger glass, or to make combination with the disc, that is rotated and

regulated by the finger while making the observation.

The instrument I present you is an improvement on Knapp's original one. It is composed of two discs, containing,



respectively, convex and concave spherical glasses, revolving immediately over each other, and so arranged that either or both discs can be worked by the fingers and thumb of the one hand holding the instrument before the eye. It is much smaller, so that it can be introduced under the brow. It has a movable mirror.

The lenses are in depth of measure as follows:

Convex, 0.5, 1, 1.5, 2, 2.5, 3, 4, 5, 6, 8, 10, 12, 16.

Concave, 0.25, 0.5, 1, 1.5, 2, 2.5, 3, 4, 5, 6, 8, 10, 16.

With these glasses any combination can be made, and any amount of hypermetropia, myopia and astigmatism can be measured.

It is made by E. Fox, N. W. corner Chestnut and Seventeenth streets, Philadelphia, and is put up in a neat case, with two large convex lenses for indirect observation.

THE EX-RESIDENT PHYSICIANS OF THE PHILADELPHIA HOSPITAL (BLOCKLEY) had a re-union and dinner last week at the Hotel Bellevue, at which Prof. Alfred Stillé presided. There were sixty-five covers laid. It was decided to hold a similar meeting next year.

THE CAUSE OF DIPHTHERIA IN OIL TOWNS.

BY EVAN O'N. KANE, M. D.

THE following query appeared in the MEDICAL TIMES for Nov. 15, 1887:

"Will some experienced guessist inform us why the oil towns have so much trouble with diphtheria? Since the development of oil territory in Washington county this disease has become very prevalent."

It does not need, I think, a "guessist" to say why this is the case. It is not the presence of the oil, but the fact that an ephemeral population is suddenly crowded into a small space. The forest is cut down immediately around them, so that the evil influence of newly exposed earth exists, while there is no sweep of health-giving winds. A camp exists with no military discipline to enforce "policing," and the quickly earned, quickly lost earnings, of the oil men, surround them with camp followers of the vilest character. In fact the oil population is a highly immoral one. Living at "high pressure," sleeping but little, drinking, dancing and gambling much, the grown people will not slumber, and their custom of turning night into day makes these hours so noisy that the children cannot sleep if they would. Then, too, the wives and mothers who have accompanied their husbands have, as a general rule, married as mere girls and know nothing of housewifery or the proper care of their children. Here we find streets of board shanties, built of damp, unseasoned lumber, the best of which are only lined with cheese-cloth, on which a cheap wall paper is pasted.

Through these houses rain and snow, frost and draughts find easy way to palliate which discomforts roaring gas-fires are kept burning, which, by the extreme alternations in temperature that they occasion, make matters only worse. The "city" has located itself in the vicinity of the wells; *ceteris paribus*, the locators of the first wells sought the lowest ground to commence drilling and the houses planted themselves by the nearest springs. Each household's garbage, wash-water and sewage of all kinds, is either thrown out of the front door to mix with the deep mire of the street,

or into the drain at the back of the house formed by the bed of the adjoining rivulet. The street, composed as it is of soft forest loam, is soon ploughed up by the heavily loaded wagons, till its mud, kept from drying by admixture with oil and sewage, is literally knee-deep, with here and there great pools of filth, which would be stagnant in the sun if it were not that all travel to or from the wells must drag through them.

The livery and boarding stables, of which every oil town has a number, are built with party walls in common with those of hotels and dwellings. They are never properly cleaned and large heaps of straw, sawdust and manure are left to rot in their corners, or are raked out on the street. Each household contains as many lodgers as can be packed into the bunks, filled with mouldy hay and straw, which literally cram the upper rooms.

When, as soon happens (if such houses are not burned for insurance), the bed-bugs and other vermin become unendurable, the house is vacated for a day, and the steam from the nearest boiler, not in use, is turned into the building, its doors and windows are closed, and it is subjected to a thorough roasting, sufficiently hot to actually cook the little intruders. After this is accomplished, the bedding is not aired and dried, but is often left to mildew in the bunks. Under such favorable conditions there is no limit to the spreading of diphtheria, once started, save the dread of infection.

This is so great that while it does not prevent the sick-room being invaded by crowds of gossips, no one can be found to help with the nursing.

Another thing very noticeable about diphtheria in our oil country, distinguishing it from that of other localities, is its tendency to become gangrenous and to terminate fatally. I think the explanation of this is not difficult; its victims are, if I may be pardoned the expression, half rotten before their infection. It would be no overestimate to say that three-fourths of all the adult inhabitants are more or less tainted by venereal disease, and in consequence their children generally show some of the landmarks, either in their peg-teeth, flattened noses, blotched

faces, and bleared eyes, or in a large-headed, clear-complexioned and strumous appearance.

Among such children the ravages of diphtheria are most felt and its remedies are often powerless to arrest it.

The wonder is not that there should be so much, but that there should be so little diphtheria.

KANE, McKean Co., Pa.

NOTES FROM PHILADELPHIA CLINICS.

A VACCINATION that "takes" at once and is well in a week, is a spurious vaccination and is no protection. Humanized virus acts more gently and certainly than bovine. Virus should not be taken from a child that has not had at least some fever; nor from one that has had high fever. If a child has a tendency to scrofula, an outbreak will probably occur after vaccination. The crust or scab should be taken on the fifteenth day, and the pus adhering to the under surface should be scraped off. At about three months of age is the best time to vaccinate, in the opinion of Prof. Waugh.

FOR dusting on the inflamed skin of a baby, oxide of zinc is good. A pinch of phosphate of soda in the milk, in cases of constipation in children, is frequently sufficient. If a child must have a purgative, Prof. Atkinson says to give it olive oil instead of castor oil.

FOR a case of lupus in the form of a fungoid, bleeding ulcer on the bridge of the nose, spreading towards the eyes and the cheeks, Prof. Shoemaker prescribed the following:

Touch the ulcer twice a week with strong carbolic acid; every day apply:

B Cinchonæ rubre.....3 ij
Bismuthi subiodidi.....3 ss
Zinci oxidi.....3 j

M.

And administer internally:

B Olei morrhuae.....3 iv
Ter in die.

AORTIC INSUFFICIENCY.—Dr. Osler exhibited at the Philadelphia Hospital two cases of aortic insufficiency in men over sixty, with visible pulsation

of the carotids, brachials, and radials, Corrigan's pulse, and hypertrophy of the left ventricle. He recommended that, as long as compensation was perfect, no treatment, except perhaps *nux vomica* or *strychnine*, should be given; but, as soon as compensation fails, *digitalis* is beneficial.

PSORIASIS.—Prof. Shoemaker uses the following treatment, with occasional changes, for psoriasis:

B. Menthol.....gr. iii
Acidi carbolici.....gtt. v
Ung. hydrarg. nit.....3j
Adipis.....3ss.

M. Ft. ung. Sig. Apply on affected parts once daily, having previously used the following to clean off the crusts, etc.:

B. Tr. saponis viridis,
Aque.....ââ f3ij

M. Sig. Put teaspoonful on sores, and wash well till lather is formed; rinse off; then apply above.

Internally he administers

B. Syrupi acidi hydriodici... gtt. v
Increase to fifteen drops thrice daily.

ULCERATIVE ENDOCARDITIS.—Dr. Osler exhibited the heart of a patient who, upon entrance, was thought to have phthisis, but in whom the post mortem indicated an acute ulcerative endocarditis; the phthisical symptoms, haemoptysis, dyspnoea, and night-sweats being due to obstruction of the lungs from the heart lesions.

CARBUNCLE.—In carbuncle, Dr. White recommended the application of a flax-seed poultice on which enough of a combination of turpentine, 3j, and compound resin cerate, 3j, had been melted to cover the whole surface of the poultice.

TO RENDER THE HANDS ASEPTIC.—For deodorizing his hands after contact with offensive discharges, Dr. Goodell first washes them with soap and water; then with turpentine; and lastly with the 1 to 1000 bichloride solution. He does not believe cancer to be inoculable, as he has repeatedly had raw surfaces upon his hands in contact with cancerous tissues.

TO AFFORD immediate relief in acute otitis.—Prof. Pancoast dips a pilet of cotton in a solution of atropine, gr. xl to 3j, and inserts it into the external auditory meatus

PROF. GERHARD has found that by applying to a chancre a solution of bichloride of mercury, 1 to 1000 or 1 to 2000, he can cure it some two weeks sooner than by the ordinary treatment.

The bichloride also acts well when used by inunction with lanoline.

PHARYNGITIS.—In cases of sore throat, especially in what is known as "minister's sore throat," Prof. Garretson advises the following formula:

B. Acidi carbolici.....gtt. xij;
Tinct. iodi comp.....gtt. lxxv;
Glycerini.....f3 ij;
Aque.....f3 ijss.

M. Sig.—Use as a gargle, properly diluted.

In his clinic at the Medico-Chirurgical College, October 21st, Prof. Shoemaker exhibited a patient cured of pemphigus, which had existed since the late war. The patient had been treated simply by hypodermic injections of arsenious acid, beginning with gr. $\frac{1}{16}$ and increasing to gr. $\frac{1}{8}$ twice a week.

A GOOD MOUTH WASH.—Prof. Garretson's favorite stimulating and cleansing wash, after an operation involving the mouth or the adjacent parts, is

B. Tinct. myrrhe.....
Tinct. capsici.....ââ f3 j
Aque.....f3 iv M.
To this some phenol or thymol might be added, if desired.

OPERATING FOR CANCER.—At his clinic at the Medico-Chirurgical College, Nov. 16, Prof. Pancoast exhibited a woman on whom he had operated fifteen years ago for cancer of the breast, and in whom, after fifteen years of immunity, the disease had lately returned. He again removed the growth, and the patient is doing well. At the same clinic he operated on a patient for epithelioma, removing all the fingers of the left hand and the first row of carpal bones, but preserving the thumb.

JABORANDI FOR ERYSIPelas.—Prof. Waugh says that since he has used jaborandi in erysipelas, he considers it an insignificant disease. He gives twenty drops of the fluid extract every two hours, until it produces perspiration. Then he remits the treatment until the erysipelas shows signs of returning, when the jaborandi is resumed. For two years he has had not the slightest difficulty with any case.

CANITIES.—In cases in which grey hairs make their appearance, a few at a time, if the white hairs are at once pulled out, pigmented hairs are likely to grow from the same follicles.—*Prof. Shoemaker.*

FOR a case of chronic sycosis, Prof. Shoemaker prescribed five drops of Donovan's solution *ter die*, and locally:

R Olei cadini..... gtt. xx
Plumbi oleatis
Lanolini..... aa 3 j

M. Apply locally.

CORNEAL INFLAMMATION.—For irritation of the cornea, Prof. Keyser considers iodine ointment the best.

R Iodi..... gr. iij
Lanolini..... 3 j
M.

ECZEMA.—Prof. Shoemaker prescribes for a very bad case of chronic eczema, involving the whole body, and of several years standing, this treatment:

R Aloini..... gr. $\frac{1}{2}$
Tinctura nuci vom..... gtt. v
Ext. hamamelis fluid..... gtt. v
Tinct. gentianae comp..... f3 j M.

Sig.—Capiat haustus *ter die*.

Give an alkaline bath three times a week, composed of two handfuls of soda to twenty gallons of water, and let him apply the following ointment:

R Bismuthi subnitratis..... 3 ij
Glycerini.....
Aqua calcis..... aa f3 iv
Creasoti..... gtt. iv
Zinci carbonatis (impur)..... 3 ss
M.

FOR OBSTINATE VOMITING.—A Seid-litz powder broken into four and one part given every fifteen minutes is sedative to the stomach.—*Prof. Woodbury.*

ANTHRAX.—Prof. Goodman prefers to scoop out a carbuncle in the case of a patient with a strong constitution, dust with iodoform and treat as an ordinary wound. In cases of a succession of boils, he gives chloride of iron and chlorate of potash.

IN OPHTHALMIA NEONATORUM, if the ulcer has not reached the cornea, order the eyes to be cleaned every half-hour with absorbent cotton, and alternately after each cleansing have applied boric acid, gr. v to 3j of water, and nitrate of silver, gr. $\frac{1}{2}$ to 3j, as recommended by Prof. Keyser.

PROF. WAUGH believes diphtheria to be at first a local disease, and considers nascent chlorine the best agent for destroying the diphtheritic patches, and thus preventing constitutional symptoms. The chlorine he makes thus:

R Potassii chloratis..... 3 j
Acidi hydrochlorici..... f3 iss
Misce et adde
Tinct. ferri chloridi..... f3 ij
Aqua, q. s., ad..... f3 iv

One drachm every two hours for a child of three years and upwards. Give a drink of water just before the medicine, no water with it, and none after.

FOR CORYZA.—Prof. Woodbury advises a purging with cascara, hot drinks, confinement to the house for a day or two, and quinine, ten to twelve grains, for several days after.

PHILADELPHIA HOSPITAL.—Dr. Musser diagnosed a case of marked thoracic and abdominal enlargement as old pleuritic effusion of the right side, with dislocation of the liver downwards, and enlargement of the right kidney, with pyelitis. The patient, a hard drinker, had had a pleurisy five years ago, and chronic malaria for some years, and is greatly emaciated.

—In a case of profuse papulo-squamous syphilitic eruption covering the entire body, Dr. White recommended bathing night and morning in warm water, rendered alkaline by washing-soda, and to which a quantity of bran has been added. After lightly drying his body, the patient powders the whole surface with calomel. With this is combined the usual internal treatment.

POETRY.

POCULUM CHARITATIS.

[Inadvertently omitted from the proceedings on the occasion of the presentation of a Loving Cup to the College of Physicians of Philadelphia.]

When Vortigern, the British King, at Thong-caster was guest,
'Tis said the maid Rowena, at her father's stern behest,
Brought forth a chalice filled with wine, and
low on bended knee,
She offered it unto the King. Then rising
gracefully,
With winsome smile and laughing eyes, and
full of loyal zeal,

She greeted him in sweetest voice, "Liever Kyning" and "wass hael!" King Vortigern was so bewitched by fair Rowena's charms, He longed to clasp the litesome maid within his brawny arms; And I believe that's what he did, 'tis true I do not know, For this erotic scene transpired twelve centuries ago. 'Twas thus from Hengist's daughter's lips, the Wassail cup received The name it bears; and hist'ry says, if it may be believed, 'Twas soon debased from its high place. At ev'ry drinking bout "Wass hael!" "Trink hael!" the roisterers would to each other shout; While deep and frequent draught's they'd take from out the wassail bowl, Until their words grew scant, and they from off their seats would roll. At first, it seemed as if the cup did foster friendship true, And on the dark and gruesome days, would let some sunshine through; That it gave strength to warrior's hearts, and to their breath as well, Making their speech quite vehement, and their hard heads to swell. But soon it led to orgies wild, to meetings in-harmonic; Instead of gently "toning up," the wassail grew teutonic. The courage which it gave was "Dutch," and men whose eyes were clear Saw that their best and gayest friends went soonest to their bier. In fact, as years rolled on, the word, at last, did come to mean Not hospitality, or mirth, but any drunken scene.

* * * * *

'Twas in the year nine-forty-three, or somewhere there about, A Benedictine Abbot, with the slightest twinge of gout, Declared that for the wassail cup a fitting place would be Upon the table at the end of the refectory. So that, when at their frugal meals, his Benedictine brothers Might take a draught of *Vinum Hip*, and offer it to others. He argued that, in wholesome deeds, in acts of charity, In welcoming the hungry poor, whoever they might be, In giving food to those who craved and drink to those athirst, Among their many duties stood in rank the very first. "Whate'er we eat, whate'er we drink, with others let us share,— To love and succor others must be every friar's care." Thus spoke the Abbott while he looked within the tempting cup; Then smilingly he gazed around and gently took it up.

He ran his nose within its depths. A pause did then ensue Which lasted 'till the Abbot's face assumed a fiery hue; Quickly then his shaven pate bobbed up again, while he Drew a deep and sudden breath and grasped his rosary. Speechless he sat a moment, then he spoke in cheerful voice, "Ah, brothers, life is very short, and fleeting are its joys; Drink while ye may; let others drink from out this cup '*free gratis*,' For this shall be a loving cup—*poculum charitatis*." And so it has come down to us—the wassail cup no longer, But the pure and warming, loving cup to make our friendships stronger,— "That maketh glad the heart of man," and turns him t'ward his brother With open hand and smiling face, and love for one another. To-night we pass the loving cup, and all you Fellows know Ours hath a charm to set our hearts with noble thoughts aglow. It comes to us from women's hands, so gen'rous and so tender; To these fair dames let each of us our grateful homage render.

[The President of the College takes the cup]:— Ah, yes, Sir Wier; take a deep draught, that you may not grow *WIERY*; You sit too near the large *FURNESS* to feel right bright and cheery. And why is *Wood* so near at hand? I am sure you'd not supply An *ASHHURST* with more fuel while you look so hot and *dry*. There's a *KEEN* fellow over there, who looks up quite astonished, As if I had *DA COSTA*'d him; but he scarce need be admonished That *GOOD'ELL* come from foolish words when they set men a laughing; Like *PEPPER*, mixed with windy food, or like the wine we're quaffing, They help us "stomach" many things we're called upon to take in; *STILLÉ* (still he) may see no good results from the effort I'm makin', So let the loving cup pass 'round. Each one of us *WOODBURY*. All harmful thought that we may be both *innocent* and merry. *BILLINGS* and cooings, too, we'll have, for "the goose it hangeth high," *Twelve dozen* men do *smile* on me when I catch *GROSS*'s eye. I know you think my jests are poor, but if they should deprive you Of animation, so to speak, there's *HARTSHORNE* to revive you.

[The name of the author of the above is unknown to the editors; our readers will join us in thanking him for his delightful effusion.—Eds. P. M. T.]

TRANSLATIONS.

INJECTION OF CARBOLIC ACID FOR HÆMORRHOIDS.—Sonnenburg, in a communication to the *Berliner Klinische Wochenschrift*, speaks highly of the utility and advantage of the injection of a concentrated solution of carbolic acid as practiced by American physicians in the treatment of hæmorrhoids. He recommends its use, as he has found the method highly serviceable during the last few months in many cases.

For the injection he prepares a solution of carbolic acid and glycerine, 1 : 4. According to the size of the hæmorrhoid, he injects from 2 to 4 drops of this solution, employing a curved needle which throws the medicament deeper into the base of the pile and with more ease and satisfaction than a straight needle. The operation is comparatively simple with hæmorrhoids situated near the external anal edge; more difficult with those seated higher up; nevertheless, with all, it requires some practice.

As a rule, he finds the injections painful the nearer they are to the external anal orifice; the pain soon disappears, however. In operations undertaken on very sensitive females the pain was scarcely noticeable.

On the fourth day, when the first movement of the bowels is obtained, the soft, sloughing hæmorrhoid causes no difficulty, neither is there any danger of complications to be feared from the use of this method.

Its advantages, as Kelsey and Lange with justice observe, are the freedom from pain, permitting the patient to follow his avocation undisturbed, and the disuse of chloroform or ether, with its dangers and disagreeable after-effects. He prefers this mode of treatment in all small or medium sized piles. For the treatment of external hemorrhoids, hypertrophic and easily prolapsed rectum, and extensive large hemorrhoids, he prefers cauterization, as practiced by Langenbeck, most decidedly.

CHRONIC PERITONITIS.—The following case is reported by Dittmer, of Berlin.

Martha B.—, 8 years of age, was prostrated with all the symptoms of an acute gastro-enteritis. The vomiting

soon subsided under ice treatment. Diarrhoea persisted obstinately. Remittent fever occurred, so that, in a week, the child presented the picture of an infantile abdominal typhus. Roseola were not found. Slight tympanites present, with pains, especially marked in the right hypochondrium.

In the middle of the second week tympanites gradually increased, with pain, spreading over the whole abdomen, so that now a beginning peritonitis was diagnosed, instead of typhus, and suspicions were directed to a probable tuberculosis of the intestines and peritoneum. The fever continued equally remittent. Diarrhoea was still present; the child emaciating rapidly. A fluid effusion could not be ascertained with certainty. This was only possible on the third of August, four weeks after the beginning of the sickness. About this time the diarrhoea lessened, also the fever. As the appetite returned, patient improved markedly. The effusion, however, increased. This continued until the end of August, when the fever again increased, the pain and tenderness of the abdomen were greater, the appetite worse. On the 29th of August, the abdomen was enormously expanded; the under edge of liver stood the breadth of three fingers above the arch of the thorax. In the right hypochondrium, about one finger's breadth above the edge of the thorax, in the mammary line, a prominent, red, fluctuating spot, about the size of a nickle had formed, under which a defect in the abdominal walls was noticeable. A second similar, bean-sized spot was observed in the linea alba near the umbilicus.

As the first spot increased in size in the next few days, and as the fever increased, with all the characteristics of pyæmia, he decided to incise. On the 2d of September, free incision was performed, when six quarts of pure, healthy and not at all bad smelling pus were discharged.

Through this incision the lower lobe of the liver could be distinctly traced; the peritoneum within and the internal muscular tissue of the abdomen without, presented such a large cavity, for pus accumulation, that its borders could not be ascertained.

Under free drainage, salicylic bandages, and daily dressing with permanganate of potash, the temperature fell to normal in the days following the operation. The threatened second perforation at the umbilicus improved and lessened. Patient recovered rapidly under the circumstances, and was able to leave her room on the 9th of October. The profuse discharge of pus decreased after the operation, the wound united and became smaller. Drainage tube was removed near the end of October, and complete recovery seemed assured, when, contrary to all expectations, the discharge of pus increased during the middle of November. Pain in the abdomen and fever followed, and in the region of the old perforation, at the umbilicus, a second perforation formed, although the incision of the old was still open and the pus discharging unhindered.

Perforation of this occurred Nov. 22d. Upon injection of the operation wound, the fluid would escape through the second perforation, and *vice versa*. The perforation was incised and drained; again the patient improved. The perforation at the navel closed about New Year's. The wound of incision, however, kept open and discharged a very small amount of thin pus.

On the 8th of March 1880, the probe was introduced into the operated perforation, entering about four inches without meeting any obstruction. Lateral motion of the body to any extent was impossible, however.

As the general health was perfectly normal, and the continual discharge of pus was disagreeable and unpleasant to the patient, the wound showing no tendency to recover, he deemed it advisable to inject tincture of iodine into the fistula, with the hope of obliterating the tract. The first injection was made on the 8th of March; then on the 12th, 19th, 27th of March, and 11th of April; they were borne well, causing no distress, and bringing about the complete and definite cure of the patient on the 15th of April, the day of her discharge.

He has had many opportunities of seeing this patient, who has during this time developed into a blooming, healthy young lady.—*Berlin Klin. Woch.*

OXYGEN IN THE TREATMENT OF ECLAMPSIA.—In two severe cases of eclampsia with albuminuria during pregnancy and labor, Bompiani (in "*L'Observatore*") employed oxygen inhalations. In the first, a fatal case, he endeavored by its use to remove the asphyxia and lung difficulty, with only temporary success; while in the second case it was used, as a last resort, to remove the oedema, anasarca and eclamptic symptoms, with marked benefit.

The first case was that of a young woman, twenty-seven years of age, who, at the termination of the labor, was attacked by recurrent convulsive paroxysms of an intense form. Bromide of potassium, chloral hydrate, leeches, warm vaginal douches, and hypodermic injections of morphine, were of no avail; coma and asphyxia increased. To relieve the latter, three balloons, of thirty litres each, of oxygen were given her to inhale. A slight improvement followed, labor was induced, and ended; yet the patient died in spite of the renewal of the inhalations.

In the second case, the patient, a young woman, at the end of labor was attacked by strong convulsions. Albumen was present in her urine, as well as in that of the first case. Forceps were applied and a living child born. Immediately after labor the attacks were renewed, when oxygen inhalations and ether injections were used, which instantly subdued and controlled the convulsions.

The author, in presenting these two cases, desires to draw no inferences; but simply calls the attention of the profession to this mode of treatment, and recommends its use in similar cases.

TREATMENT OF MALIGNANT PUSTULE BY IODINE INJECTIONS.—In a case of a butcher, 16 years of age, who was suffering with malignant pustule, M. Guyon administered five parenchymatous injections of Lugol's solution (about 1.50 Grms. in all) into the middle and around the base of the induration. Alcohol was administered internally. The patient recovered, owing, it was thought, to the antiseptic action of the iodine, both local and general.—*Gaz. Méd. de Paris.*

PHILADELPHIA
MEDICAL TIMES.

PHILADELPHIA, DEC. 15, 1887.

EDITORIAL.

CASCARA SAGRADA.

PHYSICIANS, when writing prescriptions, generally concern themselves too little with the source and character of their drugs, leaving the responsibility of their selection, preparation and dispensing in the hands of some pharmacist whose personality may be, and often is, entirely unknown to the prescriber. When, as usually happens, the prescription falls into the hands of a reputable pharmacist, the interests of both patient and physician may be scrupulously cared for; and this labor-saving arrangement is of decided practical advantage to the physician. But, on the other hand, when, as sometimes occurs, the prescription falls into the hands of a dispenser whose principles are of the commercial standard, rather than professional, the pecuniary interest of the pharmacist will then take precedence of all others. Purely commercial considerations therefore may decidedly affect the use of remedies. We do not here refer to the substitution of the cheaper alkaloids of cinchona for the more expensive ones, or the dispensing of atropine for duboisine; these are instances of fraud pure and simple, and can easily be guarded against by ordering the prescription to be filled by an honest apothecary, or, in his absence, the physician can obtain pure drugs directly from the manufacturers of established reputation.

The point which we consider of greater importance to the physician is the quality of pharmaceutical preparations of drugs as they are dispensed by

the pharmacist. The medical profession demands that preparations should be as nearly as possible of uniform composition and of standard strength; and every physician should find out reputable pharmacists, deserving of the confidence of the community, and direct their patients to them, in place of others who have no such reputation to sustain.

To the wholesale purveyors of drugs the physicians should also devote attention, and where the interests of medical science are ever held to be paramount, they also deserve acknowledgment and appreciation. If the physicians of this country do not have their prescriptions filled with pure preparations of standard quality, the fault lies with themselves; since there are firms possessing great enterprise and energy, who, at large outlay of capital and labor, succeed in verifying the true characters of the drugs which they employ, and are scrupulously careful in maintaining the quality of their products, so that they shall conform to a uniform standard of excellence. That they should do so is a matter to which no practitioner of medicine can afford to remain indifferent.

We regret the acerbity of Dr. Squibb's recent discussion of the value of one of our indigenous drugs which was introduced to the profession by Messrs. Parke, Davis & Co.; and we confess that our sympathies are with the Detroit firm in this matter. Dr. Rusby, in a valuable communication which appears on another page, and which successfully disposes of Dr. Squibb's objections, takes the correct ground when he declares that clinical experience must decide the value of remedies, and that the permanent reputation of a preparation depends upon intrinsic merit, and not upon advertising. Although printer's ink may be useful in

introducing a remedy, it will soon be laid aside if it cannot stand the crucial test of clinical experience.

Physicians are warranted in protesting against the dogmatism of the laboratory when it assumes to direct their judgment in practical therapeutics against the teachings of daily observation. We would not underrate the value of purely scientific investigation into the characters, constituents, and relations of drugs, nor of the usefulness within a limited range of physiological experimentation; but we must never forget, in the words of Professor Leyden, that "It is time to remind the practitioners of our day that the inexhaustible source of all knowledge and progress in medical art is observation at the bedside of the patient." Clinical experience has given *Rhamnus Purshiana* a position in therapeutics which the criticism of the laboratory cannot affect; it has been accorded recognition by the British Pharmacopœia, and deserves and will attain official standing in our own at an early day, in response to the general demand of the profession.

F. W.

PRACTICAL ANTISEPSIS IN OBSTETRICS.

THE general adoption of the antiseptic system in obstetric practice has been greatly obstructed by the absurdly complicated details prescribed by some authorities. The uterus and vagina of the lying-in woman were considered as repositories of poison, which required the most active treatment in order to prevent general infection of the system.

Practitioners with common sense and many years' experience well knew that many of the asserted dangers were imaginary, and hence ridiculed the elaborate campaign instituted by metropolitan teachers against the apprehended

invasion of the lying-in women by bacilli, cocci, or other infective agents. The vaginal and intra-uterine injections of strong disinfectant solutions, the vulvar antiseptic pads, and repeated douches of the genital tract during the progress of the labor, and all the other elaborate ceremonial developed under the influence of authority, threatened to swamp the germ of fact in the sea of circumstance by which it was surrounded.

Latterly, some progress has been made by cutting off all unnecessary detail, and basing practical antisepsis upon established principles.

In a recent number of the *Berliner Klinische Wochenschrift* (No. 37, 1887), Dr. W. Bokelmann, of Berlin, has, in a brief, practical paper, laid down the following rules and deductions:

The healthy puerpera is aseptic. The danger of infection comes to her from without. There being no infectious material in her genital tract, the latter requires no disinfection, in accordance with the principle that "there can be no disinfection in the absence of infectious material."

The hands and instruments of the accoucheur are probable sources of infection. These must, therefore, be thoroughly disinfected before coming in contact with the woman's genital tract.

In order to avoid introducing infectious material which may adhere to the body of the patient, the external organs must be thoroughly cleansed with soap and water, and then washed with an antiseptic solution. The vaginal canal should also be washed out once with an antiseptic solution before an examination is made.

The most practical disinfectants are solution of mercuric bichloride, 1-5000, for the hands of the accoucheur and the genitals of the patient; and a three

per cent. solution of carbolic acid for instruments.

No unnecessary examinations of the patient's genital tract should be made.

After the cleansing and antiseptic vaginal douche above mentioned, vaginal and uterine injections are needless and often harmful, and should not be used unless there is evidence of septic infection manifested by fever or offensive discharge.

Intra-uterine douches should not be practiced unless there is clear evidence of infective material in the uterine cavity.

When peri- or para-metritis are present, intra-uterine douches are of no benefit and may be injurious.

Strict cleanliness of the patient and her surroundings must be insisted upon, but too much handling of the former must be avoided.

These details are neither complicated nor difficult to carry out. They are rational, practical and efficient. G. H. B.

OF INTEREST TO PHILADELPHIA PHYSICIANS.

AN exceedingly interesting book is that of the Fairmount Park Art Association, containing the signatures of its members. Among the seventeen hundred names contained in its pages are those of nearly every distinguished Philadelphian since 1870. As an autograph book it is unique, and its value runs into thousands of dollars.

We confess that we felt disappointed to see that so very few physicians had inscribed their names in it. Out of the many who have made Philadelphia medicine famous, but forty-two names appear on this roll. Among those are four of the University staff, two of the Medico-Chirurgical, and not one of the Jefferson, Polyclinic or Woman's Col-

It is difficult to believe that Philadelphia physicians are indifferent to the merits of an association whose objects are so noble as this. Physicians are to be seen enjoying the beauties of the Park as frequently as any other class. Their homes give evidence that as individuals they are not deficient in artistic tastes.

Our explanation of their neglect of this association is this: Physicians, if busy, are terribly tormented by those pests of the day—agents, book agents, manufacturers' representatives, people who inveigle one into subscribing for works that come out in "parts," and make life miserable for many months subsequently, and annoy the physician to an extent which those outside of the profession can scarcely realize.

Hence, if a man enter the consulting room with a subscription book under his arm, he has little chance for a favorable hearing.

Our attention was attracted to this subject by noticing in the Art Union of New York a proposal to form in that city an association similar to the one which has accomplished so much good in Philadelphia. W. F. W.

LETTERS FROM SPECIAL CORRESPONDENTS.

PARIS.

PROFESSOR SEGOND ON URINARY ABSCESS ; DR. PINARD ON INDUCTION OF PREMATURE LABOR ; DR. MAURIAU ON TREATMENT OF ACUTE GONORRHEA ; M. POULET ON THE USE OF THE HIPPURATES ; THE LATE WASHINGTON CONGRESS, ETC.

By the name of *Abces Urineux* the French understand infiltration of urine, a condition often met with in urethral strictures, and one that usually requires very prompt action on the part of the physician. Professor (agréé) Paul Ségond, in a late clinic at the *Hôpital de la Charité*, gave the history of a case, and, in discussing the treatment, mentioned several details of

importance. The patient, a man of 44, had, he said, many times to battle with attacks of gonorrhœa; and, two years ago, he noticed that he had considerable difficulty in urinating. Some six weeks ago, without any cause that he knew of, he found that he had a tumor about the middle of his perineum, which increased rapidly and gave him pain in walking, and finally led him to apply to the hospital for treatment. The interne passed a sound (No. 10), and found that it encountered and passed a stricture in the bulbous portion of the urethra. The perineal swelling was ovoid, fluctuated and was painful and tender to the touch. There was no change in the color of the skin above it, nor of any ordinary manifestations of abscess. Upon pressure, it did not disappear nor empty itself into the canal. It was no doubt a subacute urinary abscess from infiltration of urine. Professor Ségond divides the complications of strictures of the urethra into three groups. First, complications arising from the natural phenomena of the stricture; that is to say, retention of urine and impassability. Next, the ascending inflammatory conditions consequent upon the primitive lesion; these may pass up to the bladder and on to ureters and kidney. The last group are: The periurethral complications, occasioned by infiltration of the surrounding tissues with the urine. It was to the last group that this patient's case belonged. The urine, in escaping into the tissues, does not produce invariably the same symptoms. It may cause simply a urinary tumor, or a urinary abscess with infiltration of urine; and the principal factor in determining which one of these will occur is the quantity and character of the urine effused into the tissues. Hunter was the first to say that the rupture of the walls was caused by ulceration behind the stricture. Civiale afterwards showed that account must be taken of the friability of the walls, and in our consideration two other elements must come in: one is the constant contraction of the bladder, and the other is the resistance given by the stricture itself, which ends in producing rupture of the urethra at the weakest point. It is a curious

fact, pointed out by Professor Guyon, no matter what form of stricture is present, it is at the level of the bulbous portion that the urethra usually gives way.

Dr. Ségond reminds us that strictures are now divided into four classes: 1st. Those caused by gonorrhœa, which are as a rule near in the bulbous region. 2d. The cicatricial strictures consecutive on chancre, and these are always near the meatus and the fossa navicularis, and more favorable for urethrotomy than dilatation. 3d. Are variable and are due to traumatism. 4th. This class consists of those in which the two factors of inflammation and traumatism are combined. The notion of gravity or benignity, according to the quantity of urine infiltrated, has not always been admitted as generally as it now is. The toxic power of urine was much studied by Ritter and Bouchard; but urine is not dangerous by simple contact, be it normal or alkaline. The quantity of the urine and its power of penetration are the only two elements of gravity.

What is to be done in presence of these complications? In the first place all abscesses must be opened. The incision should be carried along the middle line up to the urethra. All are agreed to this part of the treatment, but what is to follow is not so well established. Some surgeons maintain that as soon as the abscess is opened the stricture must be cut and a sound introduced. Others (Gosselin's school) advise us to wait five or six days before operating. As to the modern French school, who follow Professor Guyon, they never permit the idea of urethrotomy to enter their heads for at least two weeks after opening the abscess. This we believe to be the best practice whether the urinary abscess is acute or subacute. The reasons are that the acute form has pus collected in the tissues, which is in a kind of effervescence, and its virulence takes some time to subside. If you cut at once you will only provoke infection. If you wait you can clean out the wound and heal it and neutralize the septic elements, while the patient can urinate through the fistula thus created. There are cases in which the infiltration has

existed for months in which it might be advisable to operate at once, but even here it is wiser to wait. In short, then, the treatment is incision of the tumor with appropriate local applications to cure the abscess, and internal urethrotomy in two weeks afterwards.

The Induction of Premature Labor.—Dr. Pinard, at the new "Clinique d' Accouchement," discussed in a recent lecture the several methods now adopted by modern obstetricians as the best means of provoking labor. First of all, he remarked, the usual remedies that have been used and are yet believed in by the public, and by some doctors, are all of them ineffectual. These are ruta, juniperus sabina, crocus, and ergota. It is currently believed that it is dangerous to give the sulphate of quinine to women who are pregnant, through they may apparently need it for malarial complications; yet as long ago as 1873, M. Tarnier had a number of experiments made by Doctor Pinard, in which quinine was given in massive doses to women during confinement, without causing the slightest contraction of the uterus. Since that time many facts have confirmed these important experiments of Professor Tarnier, and it may be stated that quinine may as a rule be given during pregnancy without the slightest danger. A large number of other means of inducing labor, such as electricity, frictions, massage, have been tried and found wanting. Kluge proposed introducing a sponge tent into the *os uteri*, but, after trying this method here, it has been abandoned. It was found that these sponges certainly would dilate, and at the same time excite the uterine fibers to action, but it was dangerous, as the death roll showed; septic infection was almost certain and in some cases the sponge even adhered to the uterine walls to such an extent that it became part of the mucous membrane and could not be detached. It was impossible to obtain perfect antisepsis, and the introduction of the tent was difficult in primiparas, and often useless in the multipara. Kiwisch then came with his ascending vaginal douches, but with these it was impossible to succeed without making the water come from a height of at least seven feet,

thus making a real *traumatic* action that was dangerous; if made with less force, it was bound to be useless, and it did not take long to abandon this method. Barnes then proposed to introduce his colporynteurs, but this is very difficult for many reasons for the general practitioner. In primipara, it will often be found impossible, though once the os is dilated it might be tried; and in some multiparous women. This reduces the choice to Krause's method or to Tarnier's. By the first, a simple rubber sound about the diameter of a pen holder, just stiff enough not to bend when it is pushed between the membranes and yet not so rigid as to tear the coverings, is first rendered aseptic by being steeped in a disinfectant strong enough to purify it, and yet not corrode it. Two fingers are introduced into the vagina until the os is reached, and the sound is then slipped in the groove formed by the fingers until it enters the orifice, and by rotating it can be slipped between the membranes for some twelve to fourteen centimetres, or some say until it is entirely within the os. In a large number of cases this will bring about labor, but in some it takes several days (two to three), and larger and larger sounds have to be introduced. It is not without danger that this is done. The sound incrusts itself and may even strip the muscular coat so that, in Italy, it has been accused of only bringing about labor by causing endometritis. Again, the membranes are easily broken by the sound; or it may meet the placenta and bring on hemorrhage; thus this method, while it is simple, may cause not only puerperal accidents and rupture of the membranes, but also separation of the placenta, and consequently dangerous hemorrhage, so that the preference is given here to Professor Tarnier's method. It consists of a rubber tube terminated by a dilatable rubber bag, and a metallic conductor. This conductor is a branch half round in shape, and turned on the end like a male sound. The little rubber sac when dilated with water is as large as an egg. To use it the rubber tube is fixed in the metallic carrier and injections of water are used to drive out any air that is in the tube and bag,

[December 15, 1887.]

and to test the strength of the sac at the same time, notice must be taken of the quantity of water that is needed to dilate the sac. The introduction is made into the cavity of the neck as usual, except that Tarnier's instrument need not go far in, as it is a dilator as well as an exciting agent. Having placed it, the syringe quickly dilates the bag, with the proper quantity of water before determined. Dr. Pinard has used it in thirty-four cases in primipara without difficulty, and without any deaths, which cannot be said of Krause's sound. Another interesting point is in twenty accouchements, by this method, thirteen of the children were saved, though they all occurred in mothers with deformed pelvis.

Gonorrhœa.—How should acute gonorrhœa be treated according to modern ideas is a question that was answered recently by Dr. Mauriac, who has had so many years of experience in the Paris venereal hospitals. It is generally believed by the public that it is an easy thing to cut short such an attack, and many people also think that the quacks have certain advantages in this matter over the regular profession. It is owing to this that they have succeeded in making the treatment of this disease a sort of therapeutic Babel, which is mostly all confusion. A more uniform opinion ought to be established in regard to proper treatment of urethritis. The microbe theory with its gonnoccus has done nothing as yet to clear up the subject. When patients come to consult us it is almost always too late to attempt to abort the attack, because it cannot be done after twelve hours, and should be tried within six hours of the commencement of the symptoms. To succeed even then a violent substitutive inflammation by means of caustics must be produced. This can be best done with a solution of nitrate of silver, $\frac{1}{2}$ to $\frac{1}{3}$ in strength, used with Langlebert's recurrent jet syringe, or any other means that will keep the liquid within the first three or four inches of the urethral canal. This may be done two or three times every forty-eight hours, and more than this will be useless. In the intervals a one to 200th solution of sulphate of zinc may be used, and the usual pre-

scription of cubeb, copaiba and opiates should be used for a week. The above, in brief, is the best treatment, if quickly applied, and it is useless to give strong astringent injections or balsamic drugs at this stage, although they succeed in the involution phase of the disease. A few words must be said of the experience that thousands of cases has given in the new antiseptic treatment of gonorrhœa. First of all, solutions of corrosive sublimate (one or two centigrams to 200 grammes of water) were used and the effect seemed to be good; in a few days the disease appeared to be cured, but as a rule it was only a *false cure*, and the same can be said with sorrow of all the antiseptics tried: permanganate of potassium, hydrate of chloral, boric acid, resorcin, and the latest, which is as follows:

R. Quinine sulph.	1 grammme.
Aqua destill.	75 "
Glycerini.	25 "
Acid sulphuric q. s. to dissolve the quinine.	
Misce. Sig.—For a wash.	

All of these preparations *seem* to do good at first, but the disease will break out again. They only subdue some of its manifestations and do not kill the germ which mostly exerts itself in a later flow of sub-acute or muco-purulent discharge difficult to cure.

On the use of the Hippurates.—M. Poulet claims to have settled the long discussed question as to the nature of the acids in gastric juice. It is neither lactic nor hydrochloric, but it is hippuric acid. However, this acid does not exist exclusively in the stomach, except during the first part of digestion. After the first hour it is only found in feeble quantity, when it is replaced by another acid, which is also crystalizable, and that, Prof. Gautier thinks, is mesoxalic acid. When the stomach is entirely empty it seems, according to the same authority, that it secretes only tartaric acid, which is also the only acid found in the intestinal juices. A series of experiments were made on pigs, and lately on human beings, which confirms the above statements, and definitely settles the fact that hippuric acid is the acid principle of the gastric juice. From this to using hippurates is only a step which was quickly taken by M. Poulet; and

a new medication was at once inaugurated that has yielded very good results. Among the large number of diseases in which the hippurates may be used is all forms of cystitis, no matter of what origin. The first effect of the administration of hippurate of lime, in cases where the urine is alkaline, is to render it neutral, then gradually the desire to urinate frequently disappears, and all hemorrhage ceases. In chronic hepatitis, congestion of the liver, catarrhal jaundice, hypertrophic cirrhosis, and many other liver disorders, its effects are surprising. Many skin diseases are favorably influenced in their course by the hippurates, and as well as a number of maladies of the mucous membrane and dyspepsias of inflammatory origin. In diabetes it has been found an excellent remedy. The long list of rheumatic and gouty complaints find great benefit from its use, as it is admitted that there is always an increase of uric-acid that is controlled by the hippurates. The following are the modes of preparation of some of the hippurates used by Dr. Poulet:

SYRUP OF HIPPURATE OF LIME.

Pure hippuric acid.....	100 grammes.
Lime water, q. s.	
Warm water.....	2 litres
Sugar.....	5 pounds
Essence lemon.....	15 grammes

Add the lime water and the acid to the water heated to 80°, trying from time to time, until complete alkaline reaction is obtained, then add sugar and the flavor, and melt on slow fire.

Syrup of hippurate of lithium is made in the same way, using the carbonate of lithium, 8 grammes; hippuric acid, 35 grammes; warm water, 1000 grammes, and sugar, 1200 grammes. They should be given a half hour before meals, mixed with a little water, in two or three tablespoonful doses per day.

The Late Washington Congress.—Considerable remark has been made here in regard to an ill-tempered article on the Congress, which was published in a local medical journal here, and which contained some severe criticisms, denying that the sessions had any scientific value. Dr. Landolt replied, that if the author had understood the language of the country he would have seen that the papers were of great value, and that if there were present

some of the "kind of doctors America makes in two years," they stood aside, and men of real merit presented the articles. Dr. Landolt did not deny that the banquet at Pension Hall was not properly conducted, but he said America is young yet, and has not the conveniences of entertaining that old Europe has. The reference in regard to the rapidity in which doctors are manufactured in America has brought out a series of articles by one of our young doctors. M. Arthur Hugenschmidt, who studied in the United States, and even carried off the only prize given for a thesis at the Pennsylvania University last year. Dr. Hugenschmidt divides the American schools into three classes: 1st. Recognized medical schools of no great value. 2d. The medical schools of real serious merit; and, 3d. The homeopathic and women schools. He describes very well the state of the schools, and deplores the fact that Government does not take the matter in hand in regard to classical education, and not leave it to independent effort to do all; but that, however, it must not be thought that because it is true that doctors are made in some schools in America in two years, in place of the four, five and six of Europe, that there are not plenty of good practical medical schools which insist on longer time being spent within their walls, and upon a higher standard of attainments for graduation.

THOMAS LINN, M. D.

Paris, November 14th, 1887.

CHICAGO.

ONE of the most eminent surgeons of the city, Dr. Moses Gunn, died at his home, November 4th. The question now agitating the minds of physicians here is, Who is to be his successor? Dr. Charles T. Parkes has been and is now filling that chair.

Dr. John H. Hollister is testing the merits of "antifebrin" in the treatment of a large number of cases of typhoid fever at the Mercy Hospital. His results thus far have been very satisfactory, and he will shortly publish them.

The Women's Medical College has 90 students this year; Rush, about

400; College of Physicians and Surgeons, 175; Chicago Medical, 150:

Dr. N. Senn, in a recent lecture on "Septicæmia," * defined it to be a general disease, caused by the introduction into the circulation of the products of putrefaction, characterized by multiple foci of inflammation, by a continued form of fever and a peculiar complexus of nervous symptoms.

Dr. William E. Quine, in a lecture on "Typhoid Fever," summarized the exciting causes of the disease as follows:

1st. The exciting cause is a specific, poisonous, microscopical germ; and under no circumstances can typhoid fever originate from the influence of filth alone, unless that filth contains the specific germ.

2d. The germ is practically immortal. Typhoid dejecta may be imprisoned in an old cesspool or unused sewer pipe for half a century, and, then, after a lapse of this period, when this cesspool or unused sewer pipe is opened, the typhoid germ literally springs into existence with frightful malignancy, and a few whiffs from the accumulations in the cesspool will be sufficient to cause it. The germ does not die spontaneously; it can be killed.

3d. The germ multiplies in the human body, and an inconceivably minute quantity of this germ introduced into the human system makes the individual susceptible to the disease. An individual having a dozen movements of the bowels a day, each dejection contains germs enough to impart it to a hundred or thousand individuals; so there is clear proof that the germ multiplies in the human body.

4th. The specific germ of typhoid fever is eliminated by the bowels. A person may inhale the breath of a typhoid patient without danger of contracting the malady. He may lie on the same bed throughout the entire course of the disease without danger to himself, unless in some way the intestinal dejections or emanations have found their way into his own circulation. The poison is not contained in the urine, nor in the emanations from

the surface of the body, but simply in the faecal discharges.

5th. The fresh germ itself is innocuous—non-poisonous. Some investigators in Germany have engaged in the unpleasantries of drinking down fresh typhoid discharges, and have demonstrated with absolute certainty that these fresh discharges are innocuous.

6th. In order for the discharges to acquire activity or virulence they must be exposed to atmospheric air; hence old typhoid, putrid discharges undergo partial decomposition.

7th. The poison of typhoid fever is almost invariably swallowed in drinking from impregnated water supplies. It is sometimes swallowed in the food. In rare, exceptional cases, typhoid germs may be diffused through the atmosphere, and find their way into the human body through the lungs.

8th. A patient may have the disease two or three times; one attack does not protect him from subsequent attacks.

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ABSTRACTS AND GLEANINGS.

EFFECTS OF CERTAIN DRUGS AS VASO-CONSTRICTORS.—M. Trovati has made a series of experiments with the object of ascertaining the relative power of ergotine, hydrastin, and hamamelis as vaso-constrictors. When the blood contained 1-1000 of ergotine, the flow ceased in an hour. It diminished by a third in ten minutes, and by one-half in the same space of time, when it contained $2\frac{1}{2}$ and 5 parts per thousand respectively. The extract of hydrastis reduced it by two-thirds at $2\frac{1}{2}$ volumes per 1000. The extract of hamamelis, in the proportion of 1-1000, reduced the flow to one-half in ten minutes, and by two-thirds in the proportion of $2\frac{1}{2}$ per 1000. This test affords a good idea of the relative value of these drugs in the treatment of haemorrhage.

—*Med. Press and Circ.*

MASSAGE, REST AND POSITION IN SCIATICA.—Dr. Eccles, in *The Practitioner*, calls attention to the value of massage in the treatment of sciatica. His first case was one of sciatic neuritis, due to exposure. Poultices, blisters, morphine, and the cautery were used with little benefit for six weeks.

* See lecture on Pyemia, published in the PHILADELPHIA MEDICAL TIMES, Vol. XVII, p. 781.

Absolute rest in bed was enforced, the leg slung in a Salter's swing, and protected from cold. Massage was employed at first of the lightest description, but afterwards of more vigorous kinds.

Improvement was shown by the end of ten days; on the twentieth day passive motion was cautiously employed. The patient was discharged, cured, at the end of eight weeks.

WASHING THE STOMACHS OF INFANTS FOR DYSPEPSIA.—Washing out the stomach has been employed with success (Loey, in *Progrès Médical*) in nineteen infants of from one to sixteen months, seriously affected with dyspepsia. The author commences by emptying the stomach, and then he forces into it lukewarm water, slightly salted, until it comes out perfectly clear. The relief is often instantaneous; a very small number of washings daily or at intervals will effect a cure. This treatment is not by any means contra-indicated in cases of concomitant bronchitis.—*Exchange.*

[It is difficult to decide which is most reprehensible, the cruelty of a resort to such a measure as the above, in an infant one month old, or the paucity of therapeutical resources which fail to cure infantile dyspepsia without it.

It has been said, when a patient dies with typhoid fever, some one deserves hanging. Does not the spectacle of an infant having its stomach washed out, for dyspepsia, almost justify the expression of a similar sentiment?—*Eds. P. M. T.*]

THE ETIOLOGY OF CHLOROSIS.—Sir Andrew Clark, in *The Lancet*, discourses in pleasant vein the very important subject of chlorosis. To the query, Is, then, the problem of causation insoluble? he replies, "I think not. And I even venture to express the opinion that if we submit to careful examination the conditions of life which accompany the appearance of this anaemia, we shall be able to discover in them violations of physiological laws common to every case, wherever found, and sufficient through the results of these violations to explain the essential characters of the disease. In the period between the advent of

menstruation and the consummation of womanhood there arise physical, mental and moral changes which greatly influence the girl's habits of life and thought. She becomes self-conscious, and enters into new relations with those whom she meets. She thinks of her appearance and tightens her waist. Afraid of getting fat, she stints herself in food and eats of only dainty things. With her sense of modesty deepened, she is shy of being seen about the closet. Unprompted by nature, and perhaps disdainful of such affairs, she omits the daily solicitation of the bowels. And so at last it happens, through the compressed waist, the insufficient food, and the disregarded desire or the neglected trouble, that the bowels become either obstructed, confined, or inadequately relieved. In either case the faeces accumulate, are retained, and not only undergo changes in themselves, but provoke changes in the mucous membrane with which they are in contact. As one of the results of those changes, both chemical and biological, there are produced new substances, ptomaines and leucomaines, which are injurious to the organism, and which, absorbed into the blood, originate in girls of a nervous type of organization those alterations of the constitution of the blood which constitute the true pathogeny of this anaemia of girls."

PILOCARPINE IN YELLOW FEVER.—Dr. E. Hebersmith, sanitary inspector, U. S. M. H. S., reports, in the *Medical Bulletin*, a series of yellow fever cases treated by hypodermic injections of pilocarpine muriate (gr. $\frac{1}{4}$). Prompt recovery and rapid convalescence ensued in every case.

The highest temperature noted in any of the six cases was 104.4° (F.).

In a few cases under our care in 1873-5, before the days of pilocarpus, we found that all recovered in whom the temperature did not reach 105° . This was without any special medication.

UTERINE SYMPTOMS DEPENDENT UPON RECTAL DISEASE.—Dr. Mathews (in *N. E. Medical Monthly*) reports the following interesting case: A lady, age 24,

married, was referred to me by a gynecologist. History: Had complained for months of backache, pains in the thighs, general lassitude, melancholia, bearing down sensation in both the vagina and rectum, pain over site of both ovaries, constipated habit, leucorrhœa, loss of flesh, irregular menstruation, difficulty of urination, a slight discharge of mucus from the bowel. Upon the examination of the womb, the gynecologist had not seen enough trouble to account for her symptoms. He treated her several months and advised her to consult me. Upon examining the rectum with speculum, I found it highly congested, very red and sensitive. A discharge of mucus covered the entire circumference for several inches up. The cause for this extensive congestion was not discernible. I was satisfied, however, that all the symptoms mentioned were purely reflex, and proceeded to treat the rectum. Hot water injections were ordered to be taken twice daily for several days, after which the entire portion of the congested gut was brushed over with a 40 per cent. solution of nitrate of silver. After three or four days I began to make application of liquid hydrastis and water, equal parts. This was changed for the pure liquid hydrastis. The redness and pain gradually disappeared, the discharge ceased, and all reflex trouble vanished. This is but a sample case of many that have come under my observation.

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REVIEWS AND BOOK NOTICES.

A COMPLETE HAND-BOOK OF TREATMENT. By WILLIAM AITKEN, M. D., etc. EDITED WITH NOTES AND ADDITIONS, by A. D. ROCKWELL, M.D., etc. Pp. 444, 8vo. Published by E. B. Treat, New York.

This volume comprises the chapters from Aitken's practice, excised and arranged under the names of the diseases, alphabetically. In addition to his own views, the author has collated those of a large number of other writers. Of these, the majority are English; and, as might be expected, the medical officers of the Army and Navy are very

frequently quoted. This we consider the most valuable part of the work; as the high standing of these practitioners, and the care with which their cases are studied, recorded and compared, renders their work a collective investigation of a high order of merit. To them, for instance, we owe the complete demolition of Dr. George Johnson's pernicious doctrine of treating the early stages of cholera by the administration of castor oil (*vide p. 59 et seq.*). It is a curious instance of the tenacity with which some men will cling to ideas which they have themselves originated, even when their fallacy has been demonstrated, that Dr. Johnson still maintains his stand in favor of castor oil.

The arrangement of this work, under the headings of diseases, renders it infinitely superior, in convenience and practical utility as a work of reference, to the ordinary books on Therapeutics.

PHYSICIANS' VISITING LIST FOR 1888. (*Lindsay & Blakiston's.*) P. BLAKISTON'S SON & CO.

The modern visiting list has become a veritable pocket library. One after another, various schedules have been added, of such information as a physician may require in emergencies, or when absent from his office.

Of the one before us we can say that we know of no other which contains so much, and that is so carefully compiled and yet is not too bulky for the pocket.

SURGICAL DISORDERS OF THE URINARY ORGANS. By REGINALD HARRISON, F.R.C.S. Third edition. London: J. & A. Churchill, 1887. Pp. 583, 8vo.

The style is plain, concise and practical; that of a man who has no words to waste. The chapter on toxic urine is especially interesting. The author notes the fact that a wound of the floor of the urethra is more apt to be followed by fever than one situated elsewhere. He believes that urethral fever may often be avoided by preventing the urine coming in contact with the wound.

While advising gradual dilatation in the majority of strictures, the author favors the use of Holt's dilator as a stretcher in a small number. He does not mention Otis's urethrotome, though

he speaks approvingly of the urethrameter.

Nor is Newman's method of treating strictures by electrolysis mentioned; a singular fact, in view of the warm reception given Dr. Newman in England.

In the chapter on washing out the bladder, he recommends Keyes' apparatus, with a catheter opening *near* the end, "to avoid an unnecessary length of catheter being introduced into the bladder."

Dr. Harrison cannot have seen the soft rubber catheters with the eye at the end, such as are made by the Davidson Rubber Company, or he would scarcely have failed to mention them. Otherwise, his directions for irrigating the bladder are excellent; due caution being advised, but the danger not being exaggerated as it is in Belfield's book.

W. F. W.

MANUAL OF CLINICAL DIAGNOSIS. By DR. OTTO SEIFERT (Privatdozent in Würzburg) and DR. FRIEDREICH MÜLLER (Assistant to the Medical Clinic in Berlin). Third Edition. Translated by W. B. Canfield, A.M., M.D. (Berlin). With Sixty Illustrations. Pp. 173, 12mo. G. P. Putnam's Sons, 1887.

This is a plain, practical, little manual, taking up the subject from the standpoint of the student, and giving the elements of diagnosis in the clearest manner.

Chapter I. treats of the blood; its micrography in health and in disease.

Chapter II. gives in the briefest terms the diagnosis of the fevers, 11 in number. Temperature charts of each are given.

The succeeding chapters treat of the chest, the sputum, the larynx, the circulation, the pulse, the abdomen, the urine, transudations and exudations, parasites, the nervous system, concrements, metabolism and nutrition. To this is added a table of the weights of the human body, a dose table, and a copious index.

While such a work cannot be compared to the cyclopædic volume of Da Costa for the guidance of the practitioner, Drs. Seifert and Müller have chosen admirably the portion which is most suitable for the beginner. W. F. W.

LETTERS TO THE EDITORS.

It is the earnest desire of the Editors to increase the usefulness of this Journal, and to render it a practical helper to its readers. One method of accomplishing this end is to open a column devoted to letters to the Editors. Short, concise papers upon medical subjects, records of cases worth being reported, and queries on any medical subject are requested.

SHOULD PHYSICIANS BE PHARMACISTS?

Editors MEDICAL TIMES:

The writer has been much interested in reading a recent editorial in your journal upon the mutual relations of practical pharmacy and medicine. As pharmacist, and later as physician, the writer has had considerable experience on each side of the question, and has had ample opportunity to notice the practical workings of many of the points at issue. He begs therefore to submit a few additional suggestions upon the same subject, some of which are too frequently ignored or overlooked.

During latter years the somewhat strained relations which have arisen between the professions of medicine and pharmacy have been the origin of an almost endless series of complaints and recriminations from each party in the controversy, and their discussions occupy to-day a considerable space in the pages of our medical and pharmaceutical journals.

The physician accuses the pharmacist of practicing medicine by prescribing over the counter. He charges him with the unauthorized renewal of prescriptions, with substitutions in their ingredients and with adulterations of important drugs. He blames him for the sale of patent medicines, and for numerous other petty transgressions, and considers him as an impertinent invader of a territory which he, the physician, regards as particularly and exclusively his own.

On the other hand, the pharmacist regards the physician as meddlesome, and often even arbitrary and dictatorial, in his suggestions for the dispensing of remedies; he charges him with writing secret prescriptions, which can only be obtained at one particular

pharmacy, and whose formula the physician refuses to divulge; he accuses him of soliciting and extorting percentages on prescriptions; he finds fault because the doctor prescribes a host of semi-proprietary pills, emulsions, elixirs, wines, etc., instead of the officinal preparations of the pharmacopœia; he sneers at his lack of practical knowledge of the combinations and incompatibilities of remedies, while, at the same time, he is unduly sensitive upon the subject of their mutual professional relations, and smarts under the idea that the physician considers him, the pharmacist, as rather his subordinate and inferior.

Now, while both sides have certain just grounds for complaint, the most of the trouble arises from a mutual lack of comprehension of the working of certain unalterable and inevitable laws of demand and supply, by which both parties, in spite of themselves, are forced into inimical relations.

In the good old times the doctor mixed his own pills and boluses, compounded his own draughts, and then dispensed his not always palatable mixtures himself to his patients. With saddle-bags at his back, over many a mile of country, he was both doctor and druggist, and in many localities he yet, at this day, still reigns undisputed. From the days of good old Dr. Benjamin Waterhouse, who records in his ledger "A visit 2s.," or "Physick and a drench, 1s. 6d.," to the period of the modern pharmacy, with its polished counters, glittering show-cases and hissing soda-water fountain, is a long step, but still one which is but a gradual outgrowth of our social conditions. But the influence of competition—the life of trade, but often the death of profits—is responsible for the changed character of the business of the druggist at the present time. When pharmacy first stepped forth, not as the hand-maiden of medicine, but as one of its most important divisions, the occupation of the apothecary was solely that of a compounder and seller of drugs and medicines. No gaudy exhibitions of patent medicine signs, or glittering display of toilet goods and perfumery, then filled his shop windows; but instead they were modestly

arrayed, with a few specimens of familiar drugs, such as licorice-root, senna or Turkey rhubarb, with perhaps a jar of sponges or a few pieces of chemical apparatus. Those were the days when the patient and persevering toil of a Durand, a Proctor and a Parrish laid the foundations of our national pharmacopœia and dispensatory, and when the stern virtues and sterling integrity of Daniel B. Smith, Charles Marshall, Charles Ellis, Dilwyn Parrish, and many others, made the name of apothecary an honored and respected title in Philadelphia.

"Tempora mutantur et nos mutamur in illis." So, as time went on, the ranks of the pharmaceutical profession, in the more thickly settled parts of our country, filled up, finally to overflowing, and, as in other lines of trade, far beyond its legitimate need. The demand for drugs and medicines was not in itself sufficient to furnish a remunerative profit to all engaged in the business, and so to eke out an honest livelihood, the druggist commenced to sell fancy goods, soaps, toilet articles, cigars, confectionery, stationery, and almost anything else which was asked for by his customers and on which he could make a fair profit, and here is where the seed of discord was sown. While he compounded medicines and sold drugs he was free from the competition of all except his own professional brother, and as his occupation required the possession and exercise of considerable scientific knowledge, he could usually command a fair recompense for his material and for his professional skill. But when he entered the lists of trade, he entered into competition with men who needed no other knowledge than the wit to buy cheap and sell dear, and he became the same as they, a merchant. The pharmacist of to-day is essentially a merchant, with goods to sell. He must advertise his wares, he must employ the same methods to attract customers, he must cater to their needs, and counteract the wiles of his business opponents. Try to shift and deny as he may, his standard is a commercial standard, and not a professional one. Whether he consider himself as a merchant or as a professional man, it does not influence in the least his true situation, as long as the

public, who are his customers, and without whom he cannot maintain his business, regard him simply as a shop-keeper. He must sell his goods at the same prices as his outside competitors; he must keep postage stamps, directory, etc., for the public accommodation; and be he a Ph. D., Ph. G., or a simple licensed proprietor, as long as he keeps open store, the unthinking public will make no distinction. He must do the same as his neighbors; and should he attempt a revolt, and refuse to follow in the path, he will only meet with the same fate which Stephenson predicted for the cow when she tried to stop the locomotive: "vara bad for the coo." Formerly the pharmacist, by his position as an associate of the doctor, was an independent person; and, within moderate limits, could charge remunerative prices for his wares. Now, a variation of a few cents in the price is critically scrutinized, and but too often sends the customer to a competitor in business. Between the monopolization of his fancy goods trade by the large dry goods houses, the demoralization of his patent medicine business by the "cutters," and the gradual curtailing of his legitimate occupation by the inroads of homeopathy and the increase in the number of pharmacies, the professional pharmacist is to-day pushed closely to the wall, and often obliged to struggle for his life.

Now, neither can the physician prevent the pharmacist from counter-prescribing, nor can the pharmacist avoid it even if he so desires. It is a legitimate outgrowth of certain forms of the practice of medicine. For hundreds of years mankind has associated together the drug and the doctor. Where one is the other must be also; one cannot accomplish without the other; and though time and human agencies have divorced the healer of disease and the compounder of simples, into two distinct and separate classes, the public refuse to recognize the separation, and still first seek the place where the remedy for sickness is to be obtained. Sometimes they claim sufficient knowledge to select remedies, more frequently it is to ask the advice of the "doctor" at the drug store, as they term our friend the pharmacist; but, all the same, to the drug store they will go. Frequently it is from motives of econ-

omy, for the general public is not rich, and the physician's fee, in addition to the cost of medicine, is to them an item of expense which is to be avoided unless absolutely necessary. Now, unless the retail druggists as a body refuse to prescribe for the public, it is impossible for any single one to refuse to comply with their wishes without suffering a business loss. And it is improbable that the drug trade will ever attempt to do this. The trade is too lucrative and the importance of the public too great. The man who refuses to prescribe will see his customers walk away to his next corner neighbor, and get there the advice and medicine they want; he will lose his business, while the medical profession, to whose interest he has sacrificed his own, will give him no additional patronage, and probably call him a fool for his pains. Should an accident happen on the public thoroughfare the sympathizing bystanders will rush with the sufferer, not to the nearest doctor's office, but to the nearest drug store. And should the druggist refuse his offices to the injured party, he will call down upon himself such a storm of public condemnation as will fairly make him shake in his shoes. So as long as he cannot help himself, even if he would, let the doctor stop berating him, and bestir himself to find a better way to remove or modify the offending practice.

In the matter of renewing prescriptions, the pharmacist is often too severely blamed. A large majority would be glad to refuse a renewal, could they feel sure of an unwavering support from the medical profession. But so long as the great majority of the doctors fail to give any authorization to the druggist for so doing by omitting to specify on the prescription "Do not renew," they cannot complain that their wish is disregarded. The situation is like that in the fable of the monkey and the chestnut. The doctor wants the fat roasted chestnut of a frequent fee; but he don't want to burn his fingers with the wrath of his patient and lose probably his future patronage. The latter generally regards the little piece of paper as an article of value, for which he has paid money, and consequently as entirely subject to his

control. So the druggist is expected to step in as the obliging pussy cat, refuse to renew the prescription, and burn his fingers by incurring the ill-will of his customer. Let every physician forbid a renewal, and have it printed *conspicuously* on his prescription; and the outcry about renewals would soon cease.

In regard to substitution and adulteration, it must be admitted that in numerous cases the charge is a true one, and the evil is of growing dimensions. With the reduction in the margin of profits caused by the fierce business competition of the present day comes the temptation to adulterate or substitute inferior quality. No condemnation can be too severe for the man who thus trifles with human life; and if he cannot carry on his business honestly, he had better abandon it and seek some other occupation.

So much for the pharmacist. But as to the physician,—alas, poor man, what shall we say of him? Truly the lot of the general medical practitioner of the present is like that of the policeman: decidedly "not a happy one." The foes of the druggist are principally from the outside; but the enemies of the doctor are of his own household. With the gynaecologist, neurologist, laryngologist, ophthalmologist, and all the other "ologists," who monopolize his best patients and bid openly for their fees, the legion of free hospitals and dispensaries who kindly take care of that large portion of the dear public who will never pay for a thing as long as they can get it for nothing, and the druggist, who unselfishly relieves him of the venereal cases, the minor surgery, and the petty ailments, it is rather difficult to find out just what remains for the general practitioner. In fact, a recent medical writer suggests that "It would not be wise to state it definitely, lest some one should at once seize it as a new specialty," and so leave him entirely bereft. He does not like to pitch into the specialist too severely, for perchance he hopes that some day he too may become a specialist himself. But the druggist looms up before his eyes as a rank offender; as an assistant who, growing big, has usurped the dignities and

embezzled the emoluments of his employer; and he "goes for him" with all his energy.

The physician cannot advertise himself to the public except in an indirect manner, and his opportunities for gaining wealth are thus more limited. Hence poverty or cupidity often tempt him to take advantage of his position, and to exact not only his legitimate fee, but also to take unjust toll on the price of his prescription. This is downright robbery. The patient suffers, not the pharmacist; for the latter will be sure to recoup himself by increasing his charges accordingly, and the patient is thus forced to pay a double fee. Let the medical profession deny it as they will, in some localities the collection of percentages is an open and settled fact, fully proved by figures and documents.

Again, the outcry is made that the physician is too apt to prescribe various remedies, more or less proprietary in character, put up by large manufacturing concerns and introduced by skilled advertising, and thus require the druggist to carry an endless variety of such articles in stock, many of which are seldom or only once called for, and thus remain a dead loss to the proprietor. But is the physician much to blame? True, he is sometimes imposed upon by the bland and suave canvasser, and the glowing printed endorsements of his own professional brethren in favor of some new remedy—*vide* stenocarpine. But when he sells remedies in convenient and compact shape, of appearance much more elegant than those he can procure from the corner druggist, and of at least equal efficacy, is it to be wondered that he should prefer X., Y. or Z.'s manufactures to the oftentimes imperfectly prepared remedies of the pharmacopeia.

And why should the druggist complain? As long as he keeps open store he must submit to the one unalterable law of traffic, namely, the needs of the *customer* are to be supplied. He will buy Lubin's extracts for Miss Jones, and Alfred Wright's for Miss Brown; he orders the great Electric Blood Purifier for young Mr. Smith, and the Mexican Mustang Liniment for old Mrs. Higgins; why should he not keep McK.

and R.'s pills for Dr. A. and P. D. & Co.'s fluid extracts for Dr. B. Although he makes a great outcry about being obliged to carry so much stock, he in reality does it to a very limited extent, and, outside of a few standard preparations, shifts the burden on his wholesale druggist and lets him carry the supply for him. Nearly all the large manufacturers have established depots for their goods in the principal cities, and the druggist very rarely lays in a stock outside of his actual present need, unless he is sure of a steady sale. And in regard to dead stock, the druggist is a fortunate man. Let him turn to the book-publisher with his volumes that "don't take," valueless except as so much wasted paper, to the dry goods and trimming merchant, or the tailor, whose stock is subject to the caprice and whim of fashion, and to the deterioration and loss in other avenues of business, and then let him deny, if he can, that his losses in this direction are extremely light. And let him remember also that if he don't keep what is called for, some one else will, and his customers will be sure to go where their needs receive best attention.

And here let a word be said for that much abused class, the modern manufacturers of pharmaceutical specialties. Notwithstanding that they have flooded the country with their "ines" and their "ias," that the mails groan with their circulars and pamphlets, that the physician's patience and his bell-wire are alike worn out by the importunities of their canvassers, and that their gratuitous samples serve to nourish a large and flourishing army of needy patients, yet it still remains that the medical and pharmaceutical professions owe to them a great debt. It is their industry and their capital which have developed the perfection of the coated-pill, and the compressed tablet, the pancreatic ferment and the scale pepsin, the smooth and palatable cod-liver oil emulsion, and the perfected extracts of malt. To their energy do we owe the modern methods of treating disease with pre-digested and concentrated foods—a plan which has been the means of prolonging many valuable lives. They have spread the fame of American pharmacy over the entire globe, and established

its supremacy against all competitors; therefore let them receive at least just recognition and honor for their labors.

Now, to "return to our muttons." What good does all this fulmination against the druggist produce to the physician? Granted, that the druggist is a rank offender in every respect; while the physician is emptying his "vials of wrath" at the meetings of his medical societies and in his special journals, the druggist is serenely prescribing over the counter at his own sweet will, and "raking in" the dollars of his patients. He cannot be restrained by legislative enactment, for the average legislator of the present day will scent in such a move a species of close corporation business which infringes upon the liberties of the dear people, and will promptly vote it down; while there is no doubt that so many cases of great hardship would arise if druggists were totally forbidden to prescribe, that any legal enactment would defeat itself and soon become a dead letter.

And in the contest between the physician and druggist the latter has all the advantages. No code of ethics binds him in professional restraint; he can advertise freely and publicly and draw out his customers with the advertisements; the physician must wait in his office until the public seeks for his aid. The druggist has the prescription of the physician to give him an insight into methods of treatment; and, last but not least, he is in constant and continual contact with the public, can easily gain its ear, and in a thousand different ways influence it for his own particular advantage.

What then is the physician to do? I answer let him meet the druggist on his own ground, and turn druggist himself. Let him go back to first principles, and as his sires did before him, let him be both druggist and doctor, and supply himself his remedies to his patients. But let him not imagine that because he has a medical degree, he is therefore qualified to conduct a pharmacy without any further training. While pharmacy is as much a branch of the healing science as is dentistry, gynaecology, ophthalmology, or any other of its many subdivisions, it has made such progress within latter years as to raise it to almost a distinct science. The average

graduate of pharmacy of the present day is better taught than is the average recently fledged M. D. For at least four long years is the embryo pharmacist obliged to handle the mortar and pestle, and in daily contact and employment in the details of his profession, thoroughly trained, *practically* as well as theoretically, in its mysteries. On the other hand, to the shame of the medical profession be it said, that it is perfectly possible for a student to graduate from a reputable medical college, without having examined a patient, or attended a confinement. Lest this statement be deemed extravagant, the reader is referred to several letters recently published in the *N. Y. Medical Journal*, in which the fact is openly and repeatedly admitted.

So let the physician take up pharmacy either as an ante or a post-graduate course, as his means may admit, and then, after he has mastered its details, let him set down and open shop as a druggist. He will gain more patients and practice in one year than he would by waiting five years in his office.

And as for the druggist, let him in turn study medicine. If he is compelled by the exigencies of his situation to prescribe over the counter, *let him do it right*. Let him acquire the necessary knowledge of disease, and human structure and function, instead of by rule of thumb, blindly formulating his prescriptions. Instead of regarding the physician as his natural enemy, let him become his professional associate, and all the outcry about interference and counter prescribing and the like, will fade away, for each physician will control the giving out of his remedies. In fact, for the druggist, the latter course has already outlined itself. In the larger cities many of the fraternity are becoming matriculates at medical schools. In this city, a prominent Chestnut street pharmacist is now a student in the medical department of our University. And, among the writer's own circle of business acquaintances, he can number up some twenty or thirty who have either graduated as M. D., or are now taking courses in medicine.

So with the physician and pharmacist on the same ground the struggle for a livelihood can be conducted honorably

and upon an equal footing; and, should in future years competition still further diminish the margins of profit, the same condition of affairs will then probably exist in all divisions of human employment.

CHARLES L. MITCHELL, M. D.
1016 Cherry street.

THE NEW YORK LAW.

EDITORS MEDICAL TIMES:

Perhaps you are not aware that a diploma, to be registered here, must bear the endorsement of Prof. Flint, Dean of Bellevue Hospital Medical College; and, if the physician applying for such endorsement holds a foreign diploma,—i. e., granted by a college outside of the State of New York,—he must pay twenty dollars for Dr. Flint's endorsement; while the New York graduate pays nothing. I can see nothing in the Act justifying such a charge; still it is made. This simply amounts to "class legislation" in favor of New York medical colleges.

* * * *

Will the editors of the PHILADELPHIA MEDICAL TIMES inform me what are the laws of New York State in reference to the practice of medicine? I am thinking of moving to New York State to practice, but do not know what is required of a physician. L. G. S.

[The following is an abstract of the Act of June 23, 1887:]

Sec. 1 prohibits all persons from practising physic or surgery in this State (New York), unless they have attained the age of twenty-one years, are already lawfully registered, or shall be licensed by the present act.

Sec. 2 defines those to be henceforth licensed to practice as follows:

First. Graduates of New York State medical colleges, operated under the rules which are enforced by all such schools.

Second. Those receiving their degree from the University of the State of New York.

Third. Graduates of American colleges outside of the State of New York and those holding licenses to practice from European governments must have their diplomas or licences endorsed by the faculty of an incorporated medical

college in the State, or by the regents of the University on the recommendation of a legally constituted board of medical examiners in New York. The indorser may require applicants to verify their statements under oath; and any indorsement made fraudulently, with gross carelessness or ignorance, is a misdemeanor, punishable by fine.

Sec. 3 provides for the registration of those qualified under the above sections at the office of the county clerk. An affidavit is required from the applicant, who must also exhibit his diploma or license and pay a fee of one dollar.

Sec. 4 directs that a registered physician who opens an office in another county shall exhibit his registration papers to the county clerk and register again; paying twenty-five cents.

Sec. 5 directs all persons licensed to practice, but not registered, under the Act of 1880, to comply with that Act before Oct. 1, 1887; and those neglecting to do so can only thereafter register under the provisions of the present Act. It also prohibits the registration of diplomas granted *in absentia*.

Sec. 6 prohibits any person practising in the State who shall have been convicted of a felony, and provides for the punishment of fraudulent registration or unlicensed practice.

Sec. 7 confers upon county medical societies the right to prosecute illegal practitioners.

Sec. 8 excepts from the provisions of this Act all army and navy medical officers and members of the United States marine hospital service while commissioned; those actually serving as residents to incorporated hospitals; dentists; makers of surgical instruments, etc., who fit such instruments; legal practitioners of other States who cross the line for consultations; physicians who live near the State line and cross it to visit patients, but do not open an office or have a designated place to meet patients in the State; and physicians registered in one county who visit patients in others.

Sec. 9 repeals former acts inconsistent with the present.

The form of endorsement is as follows:

"To all whom it may concern, greeting:
A. B., having on the — day of —,

18—, presented to the faculty of —, a diploma purporting to have been issued on the — day of —, to said A. B., conferring on — the degree of doctor of medicine, and it being made certain to us by inquiry and examination that the said —, at the date of said diploma, was a medical college or school, duly incorporated, in good standing, and authorized to confer the degree of doctor of medicine; and, also, that the said A. B. is the identical person upon whom the said diploma was conferred, and is also a person of good moral character, who has pursued a course of study equivalent to that required of a doctor of medicine by said faculty, and is sufficiently well versed in the knowledge of physics and surgery to qualify — to practice the same.

"Now, therefore, the said faculty have caused this endorsement and the seal of the said — to be placed upon said diploma.

[Seal.] [Dean's signature.]"

This law is far more exacting than that of our own State. While it does not specifically empower the examining faculty to charge a fee, yet as it exacts an investigation which demands time, trouble and expense, and imposes a penalty for carelessness or ignorance, it seems only reasonable that such service should be paid for. We must say that we would scarcely be willing to personally incur the responsibility involved in making the above endorsement, for a fee of twenty dollars. In this State, where no penalty attaches, the fee usually charged is thirty dollars.

The legislation is clearly in favor of State Colleges; and the tendency is directly toward keeping students at their home schools. Whether this course is strictly constitutional or not has been questioned; but it is at present the law. If one State after another adopt a similar law, the restrictions upon students and practitioners will become intolerable. The true solution of the difficulty appears to us to be the appointment of a State Board, which shall examine all applicants for license, charging a uniform fee.

We would be pleased to hear from our readers upon this subject.—W. F. W.]

MISCELLANY.

DESTRUCTION BY ARTIFICIALLY INDUCED DISEASE.—The proposal attributed to M. Pasteur, that colonists should call disease to their aid for the extermination of rabbits, has properly shocked the sensibilities of the world. It has already been compared to the poisoning of wells in a hostile country, a mode of warfare which would be considered disgraceful to any civilized nation. The suggestion that artificially induced disease should be utilized for the killing of the lower animals could hardly have originated in the mind of a medical man. We hope this will be clearly understood, and that no mistake on this point will allow medicine to be accused of a thought so foreign to her best teachings. If disease came to be regarded as a means of war against pests, it would, perhaps, not be long before the revolting proposal were entertained by hostile nations for the "removal" of their enemies. Civilization places some restrictions upon the actions of individuals, and certainly a proper sentiment recoils from the proposal to thus misuse medical knowledge.—*Lancet.*

THE late Dr. Shelly, whom we knew well, informed us shortly before his death that he had never met with a case of vomiting from any cause whatsoever, which was not checked by ingluvin. Even in cancer of the stomach the good effects of this remedy were strikingly shown.

OFFICIAL LIST

OF CHANGES IN THE STATIONS AND DUTIES OF OFFICERS SERVING IN THE MEDICAL DEPARTMENT, U. S. ARMY, FROM NOV. 20, 1887, TO DEC. 3, 1887.

LT-COL. A. K. SMITH, SURGEON.—Assigned to duty as Attending Surgeon in New York City.

LT-COL. J. R. SMITH, SURGEON.—Ordered for duty as Medical Director, Department of Dakota.

MAJOR S. M. HORTON, SURGEON.—Granted six months' leave of absence on surgeon's certificate of disability.

CAPT. W. H. ARTHUR, ASSISTANT-SURGEON.—Granted two months' leave of absence, with permission to apply for two months' extension, to take effect on the arrival at Fort Niagara, N. Y., of Asst.-Surgeon Paul R. Brown.

FIRST-LIEUT. J. R. KEAN, ASSISTANT-SURGEON.—Granted two months' leave of absence, to take effect about Dec. 1st.

S. O. 269, A. G. O., Nov. 18, 1887.

So much of S. O. 235, A. G. O., Oct. 8, 1887, as relieves Lt.-Col. Chas. T. Alexander, Surgeon, from duty at St. Louis, Mo., and directs him to report for duty at Fort Meade, Dak., is amended so as to take effect Jan. 1, 1888. S. O. 274, A. G. O., Nov. 25, 1887.

CAPT. PAUL R. BROWN, ASSISTANT-SURGEON.—Ordered to Fort Niagara, N. Y.

CAPT. JOHN O. SKINNER, ASSISTANT-SURGEON.—Ordered to Fort Ontario, N. Y.

CAPT. CHAS. RICHARD, ASSISTANT-SURGEON.—Ordered to post near Denver, Col.

CAPT. E. C. CARTER, ASSISTANT-SURGEON.—Ordered to Willett's Point, N. Y.

S. O. 270, A. G. O., Nov. 19, 1887.

CAPT. H. P. BIRMINGHAM, ASSISTANT-SURGEON.—The leave of absence granted by Orders No. 52, Fort Myer, Va., Nov. 24, is extended 23 days. S. O. 255, Div. Atlantic, Nov. 28, 1887.

OFFICIAL LIST OF CHANGES OF STATIONS AND DUTIES OF MEDICAL OFFICERS OF THE U. S. MARINE HOSPITAL SERVICE, FOR THE FOUR WEEKS ENDING DECEMBER 12, 1887.

WYMAN, WALTER, SURGEON.—Granted leave of absence for thirty days, Nov. 29, 1887.

WILLIAMS, L. L., ASSISTANT-SURGEON.—Granted leave of absence for twenty-one days, Nov. 18, 1887.

KINYOUN, J. J., ASSISTANT-SURGEON.—Leave of absence extended seven days, Nov. 29, 1887.

WOODWARD, R. M., ASSISTANT-SURGEON.—Granted leave of absence for seventeen days, Dec. 5, 1887.

GASSAWAY, J. M., SURGEON.—When relieved to proceed to Cairo, Illinois, and assume charge of the service, December 9, 1887.

IRWIN, FAIRFAX, SURGEON.—Promoted and appointed Surgeon from date of oath—December 10, 1877. December 8, 1887.* To proceed to Pittsburgh, Pa., Wheeling, W. Va., Gallipolis, Ohio, Evansville, Ind., Cairo, Ill., Little Rock, Ark., Shreveport, La., New Orleans, La., Rome, Ga., Chattanooga and Nashville, Tenn., as inspector, November 12, 1887.

GUITTERAS, JOHN, PASSED ASSISTANT-SURGEON.—When relieved to proceed to Charleston, S. C., and assume charge of the service, December 12, 1887.

BANKS, C. E., PASSED ASSISTANT-SURGEON.—To proceed to Portland, Maine, and assume charge of the service, December 9, 1887.

CARMICHAEL, D. A., PASSED ASSISTANT-SURGEON.—When relieved to proceed to Washington, D. C., for temporary duty in the office of the Supervising Surgeon-General, December 9, 1887.

BEVAN, A. D., PASSED ASSISTANT-SURGEON.—Granted leave of absence for twenty days, December 7, 1887.

GLENNAN, A. H., PASSED ASSISTANT-SURGEON.—To proceed to Key West, Florida, and assume charge of the service, December 12, 1887.

* Omitted from previous report.